Journal of Traumatic Stress, 2013, 26, 557–559

"I wouldn't start from here": An alternative perspective on PTSD from ICD-11

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The PTSD diagnosis has historically been the subject of considerable controversy, even over the existence of a distinct clinical condition linked to trauma (North, Suris, Davis, & Smith, 2009). Succeeding editions of the DSM have however led to an enormous volume of research that has vindicated its introduction and established that it has characteristic antecedent events, characteristic trajectories, and distinct forms of psychological treatment. Friedman (this issue) has eloquently outlined the progress that has been made and how this evidence has prompted the improvements that are part of DSM-5. My purpose in this commentary is to question whether the current form of the diagnosis is the optimal one and to explain the thinking behind the alternative version that has been proposed for the latest revision of the World Health Organization's International Classification of Diseases (ICD-11) (Maercker et al., 2013).

The DSM-5 is intended to be a development of previous editions and, as Friedman has explained, any changes to DSM-IV-TR had to be extremely well justified by the available evidence. These principles are useful when dealing with well-established disorders but perhaps less so with such a new diagnosis as PTSD. There is an old story about a farmer who was stopped by a tourist and asked the quickest route to Tipperary. After a long pause the farmer replied "If I was going to Tipperary I wouldn't start from here". The ICD working group was under no obligation to use DSM-IV-TR or even ICD-10 as a starting point, but was charged to use their clinical and research knowledge to optimize the diagnosis in the service of clinical utility. As explained by Maercker (this issue), for WHO 'clinical utility' specifically refers to ease of use in non-specialist, minimally-resourced, and non-English-speaking settings.

At least two separate approaches to diagnostic description are possible. On the one hand manuals can provide a complete account of the characteristic features of a condition that are likely to be encountered, and specify a minimum number that have to be present. On the

other they can describe the essential features that discriminate the disorder from others and specify what must necessarily be present. Ignoring the criteria concerning the occurrence of a trauma, duration of symptoms, impairment etc., PTSD is the most complex psychiatric disorder in the DSM-5, with 20 separate symptoms organized into four symptom clusters. It differs markedly from other anxiety disorders, which generally have from two to eight symptoms, and from major depression, which has nine symptoms. Apart from the issue of clinical utility, there are at least three reasons why a simpler approach may be desirable.

The first reason is the inescapable fact of the very high rates of comorbidity associated with PTSD. This raises the question of whether comorbidity could be reduced with a more focused symptom set. A second reason has to do with the evidence that there is a subsyndromal form of the disorder, "partial PTSD", that is associated with increased impairment and with physical and psychiatric comorbidity in its own right (Cukor, Wyka, Jayasinghe, & Difede, 2010; Pietrzak, Goldstein, Southwick, & Grant, 2011). This implies the diagnostic threshold may have been set too high. A third reason is the good performance of brief screening instruments that include only a few symptoms in predicting PTSD (Brewin, 2005), which suggests that not all the symptoms included in the diagnosis may be necessary.

What are the essential features of PTSD? In addition to the symptom overlap with other disorders, matters are complicated because reactions such as re-experiencing, avoidance and numbing, and heightened arousal are typical of responses to any stressful event, not just a traumatic one (Horowitz, 1976). It is sometimes claimed PTSD is defined by the avoidance and numbing symptoms (North et al., 2009), but this is likely to be because in previous editions of the DSM this symptom cluster has a higher threshold than re-experiencing or hyperarousal. Evidence is lacking that avoidance and numbing are any more typical when similar thresholds are applied to the re-experiencing and hyperarousal symptoms. Moreover, a number of analyses indicate that the numbing symptoms are part of a non-specific

dysphoria rather than an essential aspect of the condition, whereas re-experiencing has greater specificity to PTSD (Gootzeit & Markon, 2011; Yufik & Simms, 2010).

Establishing specificity requires a comparison of PTSD with other commonly comorbid conditions, for example asking clinicians to rate the symptoms they most closely associate with different disorders. In one study that compared PTSD, depression, and GAD (Keane, Taylor, & Penk, 1997), the authors reported that PTSD was associated with four characteristic features: (a) a person presents evidence of re-experiencing life-threatening events both while awake and even while asleep; (b) that such persons remain in a condition of heightened arousal; (c) that such persons periodically act in ways to demonstrate their anger and frustration about having experienced such life-threatening events; and (d) that such persons act to avoid recollections of such life-threatening experiences that are personally and palpably painful. A recent epidemiological study investigated which symptoms were uniquely associated with different disorders, and found only two to characterize PTSD, flashback memories and dissociative amnesia (Bryant, O'Donnell, Creamer, McFarlane, & Silove, 2011).

The specific role for re-experiencing is echoed by the often-repeated claim that PTSD is essentially a disorder of memory. There is widespread agreement about the importance of involuntary images of the trauma intruding into consciousness. These intrusions are experienced to varying degrees as occurring in the present, a characteristic that distinguishes them from similar intrusions in depression (Brewin, 2011). Moreover, this sense of ‘nowness’ predicts the course of the disorder when PTSD is left untreated, as well as normalizing in the face of psychological intervention. Members of the ICD-11 working group agreed that the re-experiencing trauma in the present was a core feature of PTSD. Active avoidance and thought suppression, as well as a heightened sense of threat in the form of startle and hypervigilance, also appear to be distinct factors (Yufik & Simms, 2010) as well as maintaining factors

(Brewin & Holmes, 2003; Schell, Marshall, & Jaycox, 2004). They were also identified as distinctive features of PTSD by the clinicians surveyed by Keane et al. (1997).

These practical and scientific considerations persuaded the ICD-11 working group that it was feasible to follow previous recommendations to reduce the number of qualifying symptoms (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Spitzer, First, & Wakefield, 2007), and simply require evidence for the combination of one symptom of re-experiencing in the present, one of active avoidance, and one of heightened sense of threat, plus evidence of functional impairment to ensure the threshold for the condition remains suitably high. Re-experiencing has to be accompanied by some degree of fear or horror, but these do not have to be the most prominent emotions – this distinguishes the ICD-11 approach from a fear circuitry model and opens the door to a wider range of emotional states while still asserting the importance of one or two core emotions. Provision is also made for a more phobic response to count as re-experiencing in those instances in which the person has no conscious memory of the traumatic event. Preliminary estimates utilizing just six symptoms from the DSM-IV-TR set (B2, B3, C1, C2, D4 and D5) to model the ICD-11 proposals indicate that these proposals are unlikely to lead to much of a change in overall prevalence of PTSD, although comorbidity is reduced (Morina, van Emmerik, Andrews, & Brewin, 2012).

The process of revising the diagnostic manuals has identified a number of important gaps in the literature. Particularly lacking are studies that examine the effects of systematically varying diagnostic thresholds or that assess the incremental validity offered by including specific symptoms. Also thin on the ground are studies that seek to compare related diagnostic categories with the aim of identifying unique features. In the absence of these studies a proposal such as that for PTSD in ICD-11 must involve a substantial element of guesswork. From one perspective having two definitions of PTSD introduces an element of confusion and uncertainty; from another it acts as a stimulus to ask more searching questions

about whether it is possible to define the condition more precisely and parsimoniously. If this turns out to be possible there are likely to be substantial benefits, not only for clinical practice outside specialist settings but also for psychological, epidemiological, and biological research.

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