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Literature on *DSM-5 and ICD-11*

Although it's been more than a year since the fifth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual (DSM-5)* has been published, articles regarding the new criteria have been appearing since 2011. This is because, any revisions of the *DSM-IV* criteria for PTSD (whether removal, addition or modification of specific symptoms) had to be supported by strong empirical evidence. As a result, review articles and position papers were undertaken to synthesize all relevant empirical findings in order to guide final decisions regarding the diagnostic criteria. This process was true for all *DSM-5* diagnoses, not just for PTSD (Kupfer, Kuhl, & Regier, 2013). Given the strong empirical approach and the high burden of proof required for changing any diagnostic criterion, the *DSM-5* process was essentially conservative. Therefore, it should come as no surprise, that except for Criterion A2 (which was removed), all 17 *DSM-IV* PTSD criteria were retained although, in some cases, greatly modified. In addition three new symptoms were added. Other major changes in *DSM-5* were: 1) establishing a new *DSM-5* diagnostic category, "Trauma and Stressor-Related Disorders" for PTSD (and acute stress disorder, adjustment disorders, and others) so that PTSD is no longer classified as an anxiety disorder, 2) reconceptualizing PTSD broadly to include posttraumatic anhedonic/dysphoric, externalizing and dissociative clinical presentations along with the original fear-based anxiety disorder, and 3) establishment of preschool and dissociative subtypes.

Temporally overlapping the *DSM-5* process, the World Health Organization has been developing the eleventh edition of its *International Classification of Diseases (ICD-11)*. Although publication of *ICD-11* won't occur until 2015, it looks like the PTSD criteria will be very different than in *DSM-5*. There are a number of reasons for this: 1) *ICD-11* has endorsed a narrow approach that will focus exclusively on PTSD as a stress-induced fear-based

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anxiety disorder, 2) *ICD-11* has taken a much less conservative approach so that *DSM-5*'s requirement for a large burden of scientific proof to change any *DSM-IV* criterion has not been a guiding principle. As a result, the *ICD-11* revision looks much more drastic than *DSM-5*, and 3) *ICD-11* will include Complex PTSD as a separate diagnosis, whereas *DSM-5* will not.

With this as a background, I believe the best way to structure this guide to the literature is by identifying four different types of articles: 1) literature reviews and position papers that provide the rationale and scientific basis for *DSM-5* criteria, 2) position papers and reviews supporting proposed *ICD-11* revisions, 3) criticisms of *DSM-5*, and 4) research on *DSM-5* and/or *ICD-11* criteria.

Literature Reviews and Position Papers Regarding *DSM-5* Criteria

The following literature reviews are really position papers that were written by members of the *DSM-5* work group as they developed the *DSM-5* criteria. Most were published before *DSM-5* was finalized in 2013, therefore some recommendations in the position papers were not accepted by APA when the *DSM-5* criteria were finalized. The articles are particularly useful for providing the empirical evidence underlying the rationale for proposed revisions to *DSM-IV* criteria. Friedman et al. (2011a) provided the rationale for creating the new trauma and stressor-related disorders category in *DSM-5* (which will also be the case in *ICD-11*). At the time the article was written, there was serious consideration of expanding that category to include dissociative disorders. Because the research is mixed on whether all dissociative disorders are preceded by exposure to an aversive/traumatic event and because there was room within the *DSM-5* metastructure for two separate diagnostic categories, dissociative disorders were eventually classified separately.

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Several articles (Friedman, et al., 2011b; Kilpatrick, 2013) described the empirical data and rationale for the current *DSM-5* PTSD diagnostic criteria with a four factor model replacing *DSM-IV*'s three factor model. Scheeringa and colleagues (2012) provided the empirical data and rationale for the new PTSD preschool subtype for traumatized children six and younger; the diagnostic symptom thresholds have been lowered and subjective symptoms eliminated. Lanius and colleagues (2012) shared the evidence and rationale for inclusion of the new PTSD dissociative subtype that is based on latent class analyses, brain imaging data and a different pattern of treatment responses to current cognitive-behavioral treatments. Initially, it did not appear likely that a dissociative subtype would be accepted for *DSM-5* (See Friedman et al., 2011a). However, newer evidence changed that including findings from 25,018 respondents from 16 countries enrolled in the World Mental Health Survey showing that 14% of PTSD cases met criteria for the dissociative subtype throughout the world and that dissociation was associated with greater symptom severity, role impairment and suicidality (Stein et al., 2013). Readers who are especially interested in the Dissociative Subtype should read the special issue of the *PTSD Research Quarterly* (Volume 24/No. 4) that is devoted entirely to this topic. Finally, Hinton and Lewis-Fernandez (2011) reviewed the cross-cultural applicability and validity of PTSD. In this regard, there was a genuine effort to incorporate cross-cultural symptom expression within all *DSM-5* diagnostic categories, rather than relegating such symptoms to an appendix, as in *DSM-IV*. Friedman (2013) discussed how and why decisions were made that resulted in the final *DSM-5* PTSD criteria.

ICD-11

Because the *ICD-11* process is at least two years behind *DSM-5*, with a projected publication date in 2015, there are only a few available articles to give us a glimpse of what is to come. Three articles lay out the rationale for the narrow approach to PTSD and restriction to six symptoms (Brewin, 2013; Maerker et al., 2013; Maerker & Perkonig, 2013). This approach can be traced back to an important article by Brewin and colleagues (2009) that clearly influenced the *ICD-11* work group. Another key position paper is that providing the rationale and supporting data from latent profile analysis for inclusion of Complex PTSD in *ICD-11* (Cloitre et al., 2013).

Critiques

A number of critiques exist of *DSM-5*. Galatzer-Levy and Bryant (2013) argued that "one consequence of (the *DSM-5* PTSD symptom) expansion is that it increases the amorphous nature of the classification so that there are now "636,120 ways to have" PTSD. Young and colleagues (2014) took this one step further and argued that when the most common conditions that are comorbid with PTSD are considered (e.g., major depressive disorder, chronic pain, neurocognitive disorder due to traumatic brain injury, alcohol use disorder, somatic symptom disorder and borderline personality disorder) there are "one quintillion ways to have PTSD comorbidity." The *DSM-5* response to this is that PTSD ranked among the three psychiatric disorders with the highest inter-rater reliability in the *DSM-5* field trials, with major depressive disorder showing very low inter-rater reliability (Regier et al., 2013).

Other critiques concerned the stressor criterion, Criterion A. Roberts et al. (2012), using data from 3,013 women enrolled in The Nurses' Health Study, reprised the important question (Brewin et al., 2009) about the utility of Criterion A. Although *DSM-5* attempted to reduce ambiguity about the distinction between "traumatic" and "non-traumatic" events, these articles suggest that what really matters is whether individuals exhibit PTSD symptoms whether or not they were exposed to Criterion A events. Bensimon and colleagues (2013) argued that both *DSM-5* and *ICD-11* suffer from a Euro-American bias that makes Criterion A refer, mostly, to single traumatic incidents rather than to chronic national traumatic stress "where exposure to terror is persistent, constant and of national proportions." Zoellner and colleagues (2011) criticized the removal of PTSD from the anxiety disorders category arguing that there was insufficient evidence to do so and that there is "a compelling evidence base arguing that PTSD is an anxiety disorder." Zoellner et al. (2013) reviewed the forensic implications of the *DSM-5* revisions and argued that by increasing the heterogeneity of individuals receiving the PTSD diagnosis, there will be "continued confusion about what constitutes a traumatic stressor, difficulties with differential diagnosis, increased ease in malingering, and improper linking of symptoms to causes of behavior." Finally, Young (2014) reviewed the research domain criteria (RDoC) as an alternative approach to diagnosis with a specific emphasis on genetic-linked neurobiological endophenotypes underlying phenomenologically-based diagnostic classification schemes such as *DSM-5* and *ICD-11*. Perhaps there will be sufficient evidence to incorporate the RDoC approach into *DSM-6* or *ICD-12*, but we are not at that stage at present. There are other articles criticizing the *DSM-5* approach, in general that are beyond the scope of this review. The *Journal of Traumatic Stress* devoted a lively special section to the *DSM-5* criteria with an initial discussion (Friedman, 2013a) followed by three commentaries (Brewin, 2013; Kilpatrick, 2013; Maerker & Perkonig, 2013) and a final rebuttal (Friedman, 2013b).

Research on DSM-5 and/or ICD-11 Criteria

A big question has been how changes in *DSM-IV* criteria would affect prevalence estimates in *DSM-5*. Kilpatrick and colleagues (2013) reported results from a national sample of almost 3,000 adults recruited from an online panel. Comparing results for different definitions of Criterion A, they found that prevalence estimates for *DSM-5* were slightly lower than *DSM-IV*. The major reasons for differences were tightening of Criterion A for indirect exposure in *DSM-5*; elimination of *DSM-IV*'s A2 Criterion, and the requirement of one avoidance symptom for *DSM-5*. Miller et al. (2013) reporting on the same online civilian sample as well as a convenience sample of U.S. military Veterans found the final *DSM-5* criteria and the *DSM-IV* criteria to yield similar estimates of 16.6% and 16.4%, respectively, for lifetime PTSD. Utilizing confirmatory factor analyses, these authors demonstrated the goodness-of-fit of the four factor *DSM-5* model of PTSD. Item-response theory analyses indicated that psychogenic amnesia (D1) and reckless/self-destructive behavior deviated from other symptoms in their respective symptom cluster. Elhai et al. (2012), reporting on data from college students, found small differences in prevalence estimates between *DSM-IV* and *DSM-5*. Their data also conformed well with the *DSM-5* four factor model.

Finally, correlations with depression were not enhanced, as expected, in *DSM-5*, despite addition of two symptoms in the Negative Mood and Cognitions category. Carmassi and colleagues (2013) found 87% overlap in PTSD diagnosis between *DSM-IV* and *DSM-5* among Armenian high school earthquake survivors. Major reasons for non-overlap were the requirement of at least one avoidance symptom.

Another set of published works have addressed PTSD trajectories, assessment, and its relationship to depression. Santiago et al. (2013) reviewed longitudinal studies published between 1988 and 2010 and found that PTSD due to intentional causes increased over time, whereas non-intentional trauma-related PTSD trajectories decreased over time. Koffel, Polusny, Arbisi & Erber (2012) utilizing pre/post- deployment data from National Guard servicemembers deployed to Iraq, observed that increased anger was most closely associated with PTSD whereas negative expectations and aggressive behaviors were less specific, showing equivalent correlations with depression and substance use.

Two articles have shown good correlations between PTSD's negative mood and cognitions factor and depressive symptoms, especially the non-somatic depression factor (Biehn et al., 2013; Contractor et al., 2014). This is consistent with Koffel et al. (2012) and the general concerns of the *ICD-11* work group regarding the nonspecificity of these symptoms. On the other hand, it is inconsistent with Elhai et al. (2012) who found a negligible change in depression co-morbidity in *DSM-5*.

With the change in diagnostic criteria, it is crucial that PTSD assessment instruments be revised accordingly. Weathers, Marx, Friedman & Schnurr (2014) provide a thoughtful review of how each *DSM-5* PTSD symptom has been translated in the new revision of the Clinician Administered PTSD Scale for *DSM-5* (CAPS-5). They conclude that published and future studies are likely to show "substantial diagnostic correspondence" between *DSM-IV* and *DSM-5* with the latter being "somewhat more conservative" and "restrictive."

Two important papers comparing *DSM-5* with *ICD-11* have appeared although others are in various stages of preparation. O'Donnell et al. (2014) compared PTSD prevalence according to *DSM-IV*, *DSM-5*, *ICD-10* and *ICD-11* criteria respectively among 510 randomly selected injury patients assessed 72 months post-trauma. *ICD-11* prevalence, co-morbidity with depression and disability rates were lower than with the other three systems. Although there was great overlap between individuals who met both *DSM-5* and *ICD-11* criteria, a substantial number met criteria for one but not for the other. Similar findings were reported by Stein et al. (2014) from 23,936 respondents from 13 countries included in the World Mental Health Survey. Only one-third of broadly defined cases met criteria in all four classification schemes (e.g., *DSM-IV/5* and *ICD-10/11*) and another third met PTSD criteria in only one of the four systems. The authors concluded that "all four definitions (of PTSD) are providing information on unique clinically significant cases that are omitted from the other systems" so that "any one diagnostic system will overlook many individuals who suffer from clinically significant symptoms including distress and impairment" (page 502).

The controversy about whether complex PTSD is a unique, empirically based diagnosis in its own right has raged for decades. Resick and colleagues (2012) concluded that "available evidence does not support a new diagnostic category at this time. (See also Friedman et al., 2011a; Friedman, 2013a). Based on such reviews of the literature, complex PTSD was not included in *DSM-5* although Sar (2011) provided a thoughtful argument for its adoption as a subtype of *DSM-5* PTSD. On the other hand, *ICD-11* came to a very different conclusion and decided to include Complex PTSD as a unique diagnosis, with the condition that such individuals must first meet PTSD diagnostic criteria (Maerker et al., 2013). Cloitre et al., (2013) utilizing latent profile analysis on 302 treatment seeking individuals, concluded that there is a valid distinction between PTSD and complex PTSD. Wolf et al., (2014) disagreed on the basis of data collected from 2,695 community participants and 323 Veterans. They not only concluded that their results do not support a distinction between PTSD and complex PTSD but that Cloitre and associates would have come to the same conclusion had they utilized a factor mixed model analysis. Finally, Knefel and Lueger-Schuster (2013) reported PTSD prevalence among 229 Austrian adult survivors of childhood abuse with regard to *ICD-10* (53%) and *ICD-11* (17%). When individuals with complex PTSD are included, *ICD-11* prevalence is increased to 38%, indicating that it is "highly relevant for individuals with a complex trauma history."

Final Remarks

It is apparent from this brief review of the new literature on *DSM-5* and *ICD-11* that we have just begun to investigate the scientific and clinical implications of these very different sets of diagnostic criteria which are based on very different conceptualizations of PTSD. These controversies will definitely result in important new research that will advance our scientific understanding of PTSD in order to develop the best treatments for PTSD.

FEATURED ARTICLES

Biehn, T.L., Elhai, J.D., Seligman, L.D., Tamburrino, M., Armour, C., and Forbes, D. (2013). **Underlying dimensions of *DSM-5* posttraumatic stress disorder and major depressive disorder symptoms.** *Psychological Injury and Law*, 6, 290-298. doi:10.1007/s12207-013-9177-4 This study examined the relationship between the underlying latent factors of major depression symptoms and *DSM-5* PTSD symptoms (American Psychiatric Association, 2013). A nonclinical sample of 266 participants with a trauma history participated in the study. Confirmatory factor analyses were conducted to evaluate the fit of the *DSM-5* PTSD model and dysphoria model, as well as a depression model comprised of somatic and nonsomatic factors. The *DSM-5* PTSD model demonstrated somewhat better fit over the dysphoria model. Wald tests indicated that PTSD's negative alterations in cognitions and mood factor was more strongly related to depression's nonsomatic factor than its somatic factor. This study furthers a nascent line of research examining the relationship between PTSD and depression factors in order to better understand the nature of the high comorbidity rates between the two disorders. Moreover, this study provides an initial analysis of the new *DSM-5* diagnostic criteria for PTSD.

Brewin, C.R., Lanius, R.A., Novac, A., Schnyder, U., and Galea, S. (2009). **Reformulating PTSD for DSM-V: Life after Criterion A.** *Journal of Traumatic Stress*, 22, 366-373. doi:10.1002/jts.20443

The diagnosis of PTSD has been criticized on numerous grounds, but principally for three reasons (a) the alleged pathologizing of normal events, (b) the inadequacy of Criterion A, and (c) symptom overlap with other disorders. The authors review these problems along with arguments why the diagnosis is nevertheless worth retaining in an amended form. A proposal for *DSM-V* is put forward that involves abolishing Criterion A, narrowing the B criteria to focus on the core phenomena of flashbacks and nightmares, and narrowing the C and D criteria to reduce overlap with other disorders. The potential advantages and disadvantages of this formulation are discussed.

Carmassi, C., Akiskal, H.S., Yong, S.S., Stratta, P., Calderani, E., Massimetti, E., et al. (2013). **Post-traumatic stress disorder in DSM-5: Estimates of prevalence and criteria comparison versus DSM-IV-TR in a non-clinical sample of earthquake survivors.** *Journal of Affective Disorders*, 151, 843-848. doi:10.1016/j.jad.2013.07.020

Background: The latest edition of *DSM* (*DSM-5*) introduced important revisions to PTSD symptomatological criteria, such as a four-factor model and the inclusion of new symptoms. To date, only a few studies have investigated the impact that the proposed *DSM-5* criteria will have on prevalence rates of PTSD. **Methods:** An overall sample of 512 adolescents who survived the L'Aquila 2009 earthquake and were previously investigated for the presence of full and partial PTSD, using *DSM-IV-TR* criteria, were reassessed according to *DSM-5* criteria. All subjects completed the Trauma and Loss Spectrum-Self Report (TALS-SR). **Results:** A *DSM-5* PTSD diagnosis emerged in 39.8% of subjects, with a significant difference between the two sexes ($p < 0.001$), and an overall 87.1% consistency with *DSM-IV-TR*. Most of the inconsistent diagnoses that fulfilled *DSM-IV-TR* criteria but not *DSM-5* criteria can be attributed to the subjects not fulfilling the new criterion C (active avoidance). Each *DSM-5* symptom was more highly correlated with its corresponding symptom cluster than with other symptom clusters, but two of the new symptoms showed moderate to weak item-cluster correlations. Among *DSM-5* PTSD cases: 7 (3.4%) endorsed symptom D3; 151 (74%) D4; 28 (13.7%) both D3 and D4; 75 (36.8%) E2. **Limitations:** The use of a self-report instrument; no information on comorbidity; homogeneity of study sample; lack of assessment on functional impairment; the rates of *DSM-IV-TR* qualified PTSD in the sample was only 37.5%. **Conclusions:** This study provides an inside look at the empirical performance of the *DSM-5* PTSD criteria in a population exposed to a natural disaster, which suggests the need for replication in larger epidemiological samples.

Cloitre, M., Garvert, D.W., Brewin, C.R., Bryant, R.A., and Maercker, A. (2013). **Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis.** *European Journal of Psychotraumatology*, 4, 1-12. doi:10.3402/ejpt.v4i0.20706 **Background:** The WHO International Classification of Diseases, 11th version (*ICD-11*), has proposed two related diagnoses, PTSD and complex PTSD within the spectrum of trauma and stress-related disorders. **Objective:** To use latent profile analysis (LPA) to determine whether there are classes of individuals that are distinguishable according to the PTSD and complex PTSD symptom profiles and to identify

potential differences in the type of stressor and severity of impairment associated with each profile. **Method:** An LPA and related analyses were conducted on 302 individuals who had sought treatment for interpersonal traumas ranging from chronic trauma (e.g., childhood abuse) to single-incident events (e.g., exposure to 9/11 attacks). **Results:** The LPA revealed three classes of individuals: (1) a complex PTSD class defined by elevated PTSD symptoms as well as disturbances in three domains of self-organization: affective dysregulation, negative self-concept, and interpersonal problems; (2) a PTSD class defined by elevated PTSD symptoms but low scores on the three self-organization symptom domains, and (3) a low symptom class defined by low scores on all symptoms and problems. Chronic trauma was more strongly predictive of complex PTSD than PTSD and, conversely, single-event trauma was more strongly predictive of PTSD. In addition, complex PTSD was associated with greater impairment than PTSD. The LPA analysis was completed both with and without individuals with borderline personality disorder (BPD) yielding identical results, suggesting the stability of these classes regardless of BPD comorbidity. **Conclusion:** Preliminary data support the proposed *ICD-11* distinction between PTSD and complex PTSD and support the value of testing the clinical utility of this distinction in field trials. Replication of results is necessary.

Contractor, A.A., Durham, T.A., Brennan, J.A., Armour, C., Wutrick, H.R., Frueh, B.C., et al. (2014). **DSM-5 PTSD's symptom dimensions and relations with major depression's symptom dimensions in a primary care sample.** *Psychiatry Research*, 215, 146-153. doi:10.1016/j.psychres.2013.10.015

Existing literature indicates significant comorbidity between PTSD and major depression. We examined whether PTSD's dysphoria and mood/cognitions factors, conceptualized by the empirically supported four-factor *DSM-5* PTSD models, account for PTSD's inherent relationship with depression. We hypothesized that depression's somatic and non-somatic factors would be more related to PTSD's dysphoria and mood/cognitions factors than other PTSD model factors. Further, we hypothesized that PTSD's arousal would significantly mediate relations between PTSD's dysphoria and somatic/non-somatic depression. Using 181 trauma-exposed primary care patients, confirmatory factor analyses (CFA) indicated a well-fitting *DSM-5* PTSD dysphoria model, *DSM-5* numbing model and two-factor depression model. Both somatic and non-somatic depression factors were more related to PTSD's dysphoria and mood/cognitions factors than to re-experiencing and avoidance factors; non-somatic depression was more related to PTSD's dysphoria than PTSD's arousal factor. PTSD's arousal did not mediate the relationship between PTSD's dysphoria and somatic/non-somatic depression. Implications are discussed.

Elhai, J.D., Miller, M.E., Ford, J.D., Biehn, T.L., Palmieri, P.A., and Frueh, B.C. (2012). **Posttraumatic stress disorder in DSM-5: Estimates of prevalence and symptom structure in a nonclinical sample of college students.** *Journal of Anxiety Disorder*, 26, 58-64. doi:10.1016/j.janxdis.2011.08.013 We empirically investigated recent proposed changes to the PTSD diagnosis for *DSM-5* using a non-clinical sample. A web survey was administered to 585 college students using the Stressful Life Events Screening Questionnaire to assess for trauma exposure but with additions for the proposed traumatic stressor changes in *DSM-5* PTSD.

For the 216 subjects endorsing previous trauma exposure and nominating a worst traumatic event, we administered the original PTSD Symptom Scale based on *DSM-IV* PTSD symptom criteria and an adapted version for *DSM-5* symptoms, and the Center for Epidemiological Studies-Depression Scale. While 67% of participants endorsed at least one traumatic event based on *DSM-IV* PTSD's trauma classification, 59% of participants would meet *DSM-5* PTSD's proposed trauma classification. Estimates of current PTSD prevalence were .4-1.8% points higher for the *DSM-5* (vs. the *DSM-IV*) diagnostic algorithm. The *DSM-5* symptom set fit the data very well based on confirmatory factor analysis, and neither symptom set's factors were more correlated with depression.

Friedman, M.J. (2013a). **Finalizing PTSD in DSM-5: Getting here from there and where to go next.** *Journal of Traumatic Stress*, 26, 548-556. doi:10.1002/jts.21840 The process that resulted in the diagnostic criteria for PTSD in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association) was empirically based and rigorous. There was a high threshold for any changes in any *DSM-IV* diagnostic criterion. The process is described in this article. The rationale is presented that led to the creation of the new chapter, "Trauma- and Stressor-Related Disorders," within the *DSM-5* metastructure. Specific issues discussed about the *DSM-5* PTSD criteria themselves include a broad versus narrow PTSD construct, the decisions regarding Criterion A, the evidence supporting other PTSD symptom clusters and specifiers, the addition of the dissociative and preschool subtypes, research on the new criteria from both Internet surveys and the *DSM-5* field trials, the addition of PTSD subtypes, the non-inclusion of complex PTSD, and comparisons between *DSM-5* versus the World Health Association's forthcoming International Classification of Diseases (*ICD-11*) criteria for PTSD. The PTSD construct continues to evolve. In *DSM-5*, it has moved beyond a narrow fear-based anxiety disorder to include dysphoric/anhedonic and externalizing PTSD phenotypes. The dissociative subtype may open the way to a fresh approach to complex PTSD. The preschool subtype incorporates important developmental factors affecting the expression of PTSD in young children. Finally, the very different approaches taken by *DSM-5* and *ICD-11* should have a profound effect on future research and practice.

Friedman, M.J., Resick, P.A., Bryant, R.A., Strain, J., Horowitz, M., and Spiegel, D. (2011a). **Classification of trauma and stressor-related disorders in DSM-5.** *Depression and Anxiety*, 28, 737-749. doi:10.1002/da.20845 This review examines the question of whether there should be a cluster of disorders, including the adjustment disorders (ADs), acute stress disorder (ASD), PTSD, and the dissociative disorders (DDs), in a section devoted to abnormal responses to stress and trauma in the *DSM-5*. Environmental risk factors, including the individual's developmental experience, would thus become a major diagnostic consideration. The relationship of these disorders to one another is examined and also their relationship to other anxiety disorders to determine whether they are better grouped with anxiety disorders or a new specific grouping of trauma and stressor-related disorders. First how stress responses have been classified since *DSM-III* is reviewed.

The major focus is on PTSD because it has received the most attention, regarding its proper placement among the psychiatric diagnoses. It is discussed whether PTSD should be considered an anxiety disorder, a stress-induced fear circuitry disorder, an internalizing disorder, or a trauma and stressor-related disorder. Then, ASD, AD, and DD are considered from a similar perspective. Evidence is examined pro and con, and a conclusion is offered recommending inclusion of this cluster of disorders in a section entitled "Trauma and Stressor-Related Disorders." The recommendation to shift ASD and PTSD out of the anxiety disorders section reflects increased recognition of trauma as a precipitant, emphasizing common etiology over common phenomenology. Similar considerations are addressed with regard to AD and DD.

Friedman, M.J., Resick, P.A., Bryant, R.A., and Brewin, C.R. (2011b). **Considering PTSD for DSM-5.** *Depression and Anxiety*, 28, 750-769. doi:10.1002/da.20767 This is a review of the relevant empirical literature concerning the *DSM-IV-TR* diagnostic criteria for PTSD. Most of this work has focused on Criteria A1 and A2, the two components of the A (Stressor) Criterion. With regard to A1, the review considers: (a) whether A1 is etiologically or temporally related to the PTSD symptoms; (b) whether it is possible to distinguish "traumatic" from "non-traumatic" stressors, and (c) whether A1 should be eliminated from *DSM-5*. Empirical literature regarding the utility of the A2 criterion indicates that there is little support for keeping the A2 criterion in *DSM-5*. The B (reexperiencing), C (avoidance/numbing) and D (hyperarousal) criteria are also reviewed. Confirmatory factor analyses suggest that the latent structure of PTSD appears to consist of four distinct symptom clusters rather than the three-cluster structure found in *DSM-IV*. It has also been shown that in addition to the fear-based symptoms emphasized in *DSM-IV*, traumatic exposure is also followed by dysphoric, anhedonic symptoms, aggressive/externalizing symptoms, guilt/shame symptoms, dissociative symptoms, and negative appraisals about oneself and the world. A new set of diagnostic criteria is proposed for *DSM-5* that: (a) attempts to sharpen the A1 criterion, (b) eliminates the A2 criterion, (c) proposes four rather than three symptom clusters, and (d) expands the scope of the B-E criteria beyond a fear-based context. The final sections of this review consider: (a) partial/subsyndromal PTSD, (b) disorders of extreme stress not otherwise specified (DESNOS)/complex PTSD, (c) cross-cultural factors, (d) developmental factors, and (e) subtypes of PTSD.

Hinton, D.E., and Lewis-Fernández, R. (2011). **The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5.** *Depression and Anxiety*, 28, 783-801. doi:10.1002/da.20753 *Background:* There is considerable debate about the cross-cultural applicability of the PTSD category as currently specified. Concerns include the possible status of PTSD as a Western culture-bound disorder and the validity of individual items and criteria thresholds. This review examines various types of cross-cultural validity of the PTSD criteria as defined in *DSM-IV-TR*, and presents options and preliminary recommendations to be considered for *DSM-5*. *Methods:* Searches were conducted of the mental health literature, particularly since 1994, regarding cultural-, race-, or ethnicity-related factors that might limit the universal applicability of the diagnostic criteria of PTSD in *DSM-IV-TR* and the possible criteria

for *DSM-5*. **Results:** Substantial evidence of the cross-cultural validity of PTSD was found. However, evidence of cross-cultural variability in certain areas suggests the need for further research: the relative salience of avoidance/numbing symptoms, the role of the interpretation of trauma-caused symptoms in shaping symptomatology, and the prevalence of somatic symptoms. This review also indicates the need to modify certain criteria, such as the items on distressing dreams and on foreshortened future, to increase their cross-cultural applicability. Text additions are suggested to increase the applicability of the manual across cultural contexts: specifying that cultural syndromes—such as those indicated in the *DSM-IV-TR* Glossary—may be a prominent part of the trauma response in certain cultures, and that those syndromes may influence PTSD symptom salience and comorbidity. **Conclusions:** The *DSM-IV-TR* PTSD category demonstrates various types of validity. Criteria modification and textual clarifications are suggested to further improve its cross-cultural applicability.

Kilpatrick, D.G., Resnick, H.S., Milanak, M.E., Miller, M.W., Keyes, K.M., and Friedman, M.J. (2013). **National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria.** *Journal of Traumatic Stress, 26*, 537-547. doi:10.1002/jts.21848 Prevalence of PTSD defined according to *DSM-5* (2013) and *DSM-IV* (1994) was compared in a national sample of U.S. adults ($N = 2,953$) recruited from an online panel. Exposure to traumatic events, PTSD symptoms, and functional impairment were assessed online using a highly structured, self-administered survey. Traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm. PTSD caseness was determined using Same Event (i.e., all symptom criteria met to the same event type) and Composite Event (i.e., symptom criteria met to a combination of event types) definitions. Lifetime, past-12-month, and past 6-month PTSD prevalence using the Same Event definition for *DSM-5* was 8.3%, 4.7%, and 3.8% respectively. All 6 *DSM-5* prevalence estimates were slightly lower than their *DSM-IV* counterparts, although only 2 of these differences were statistically significant. *DSM-5* PTSD prevalence was higher among women than among men, and prevalence increased with greater traumatic event exposure. Major reasons individuals met *DSM-IV* criteria, but not *DSM-5* criteria were the exclusion of nonaccidental, nonviolent deaths from Criterion A, and the new requirement of at least 1 active avoidance symptom.

Koffel, E., Polusny, M.A., Arbisi, P.A., and Erbes, C.R. (2012). **A preliminary investigation of the new and revised symptoms of posttraumatic stress disorder in DSM-5.** *Depression and Anxiety, 29*, 731-738. doi:10.1002/da.21965 **Background:** Research has shown that PTSD is highly comorbid with other mental disorders. The *DSM-5* marks an opportunity to increase the differential diagnosis of PTSD by emphasizing symptoms that are specific to PTSD and deemphasizing symptoms that are common to many mental disorders. This study analyzes the new and revised PTSD symptom criteria proposed for *DSM-5* by examining their relations with diagnoses and measures of PTSD. In addition, we report the specificity of *DSM-5* symptoms with PTSD compared to depressive disorders and substance use. **Methods:** This study utilized pre- and postdeployment data collected from a sample of 213 National Guard Brigade Combat Team soldiers who were deployed to Iraq.

Questionnaire data were collected pre- and postdeployment and interview data were collected postdeployment. Scales to measure the *DSM-5* symptoms were created using structural analyses and were correlated with interview and self-report measures of PTSD, depression, and substance use. **Results:** The *DSM-5* symptom of anger shows the most increase from pre- to postdeployment in participants diagnosed with PTSD. In addition, this scale showed the strongest relation to PTSD and showed some evidence of specificity. Other symptom scales, including those measuring negative expectations and aggressive behaviors, showed equivalent correlations with PTSD, depression, and substance use. **Conclusions:** It will be important to continue studying the specificity of anger with PTSD. Several of the other new and revised *DSM-5* symptoms appear to be nonspecific, and it is unlikely that their inclusion in the diagnostic criteria for PTSD will improve differential diagnosis.

Lanius, R.A., Brand, B., Vermetten, E., Frewen, P.A., and Spiegel, D. (2012). **The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications.** *Depression and Anxiety, 29*, 701-708. doi:10.1002/da.21889 **Background:** Clinical and neurobiological evidence for a dissociative subtype of PTSD has recently been documented. A dissociative subtype of PTSD is being considered for inclusion in the forthcoming *DSM-5* to address the symptoms of depersonalization and derealization found among a subset of patients with PTSD. This article reviews research related to the dissociative subtype including antecedent, concurrent, and predictive validators as well as the rationale for recommending the dissociative subtype. **Methods:** The relevant literature pertaining to the dissociative subtype of PTSD was reviewed. **Results:** Latent class analyses point toward a specific subtype of PTSD consisting of symptoms of depersonalization and derealization in both Veteran and civilian samples of PTSD. Compared to individuals with PTSD, those with the dissociative subtype of PTSD also exhibit a different pattern of neurobiological response to symptom provocation as well as a differential response to current cognitive behavioral treatment designed for PTSD. **Conclusions:** We recommend that consideration be given to adding a dissociative subtype of PTSD in the revision of the *DSM*. This facilitates more accurate analysis of different phenotypes of PTSD, assist in treatment planning that is informed by considering the degree of patients' dissociativity, will improve treatment outcome, and will lead to much-needed research about the prevalence, symptomatology, neurobiology, and treatment of individuals with the dissociative subtype of PTSD.

Miller, M.W., Wolf, E.J., Kilpatrick, D., Resnick, H., Marx, B.P., Holowka, D.W., et al. (2013). **The prevalence and latent structure of proposed DSM-5 posttraumatic stress disorder symptoms in U.S. national and Veteran samples.** *Psychological Trauma: Theory, Research, Practice, and Policy, 5*, 501-512. doi:10.1037/a0029730 The Diagnostic and Statistical Manual, Fourth Edition (*DSM-IV*) is currently undergoing revisions in advance of the next edition, *DSM-5*. The *DSM-5* posttraumatic stress disorder workgroup has proposed numerous changes to the PTSD diagnosis. These include the addition of new symptoms, revision of existing ones, and a new four-cluster organization (Friedman, Resick, Bryant, & Brewin, 2011). We conducted two Internet-based surveys to provide preliminary information about how proposed changes

might impact PTSD prevalence and clarify the latent structure of the new symptom set. We used a newly developed instrument to assess event exposure and lifetime and current *DSM-5* PTSD symptoms among a nationally representative sample of American adults ($N = 2,953$) and a clinical convenience sample of U.S. military Veterans ($N = 345$). Results from both samples indicated that the originally proposed *DSM-5* symptom criteria (i.e., requiring 1 B, 1 C, 3 D, and 3 E symptoms) yielded considerably lower PTSD prevalence estimates compared with *DSM-IV* estimates. These estimates were more comparable when the *DSM-5* D and E criteria were relaxed to 2 symptoms each (i.e., the revised proposal). Confirmatory factor analyses (CFA) indicated that the factor structure implied by the four-symptom criteria provided adequate fit to the data in both samples, and a *DSM-5* version of a dysphoria model (Simms, Watson, & Doebbeling, 2002) yielded modest improvement in fit. Item-response theory and CFA analyses indicated that the psychogenic amnesia and new reckless/self-destructive behavior symptom deviated from the others in their respective symptom clusters. Implications for final formulations of *DSM-5* PTSD criteria are discussed.

O'Donnell, M.L., Alkemade, N., Nickerson, A., Creamer, M., McFarlane, A.C., Silove, D., et al. [in press] **Impact of the diagnostic changes to post-traumatic stress disorder for *DSM-5* and the proposed changes to *ICD-11***. *British Journal of Psychiatry*. *Background*: There have been changes to the criteria for diagnosing PTSD in *DSM-5* and changes are proposed for *ICD-11*. *Aims*: To investigate the impact of the changes to diagnostic criteria for PTSD in *DSM-5* and the proposed changes in *ICD-11* using a large multisite trauma-exposed sample and structured clinical interviews. *Method*: Randomly selected injury patients admitted to four hospitals were assessed 72 months post trauma ($n = 510$). Structured clinical interviews for PTSD and major depressive episode, as well as self-report measures of disability and quality of life were administered. *Results*: Current prevalence of PTSD under *DSM-5* scoring was not significantly different from *DSM-IV* (6.7% v. 5.9%, $z = 0.53$, $p = 0.59$). However, the *ICD-11* prevalence was significantly lower than *ICD-10* (3.3% v. 9.0%, $z = -3.8$, $p < 0.001$). The PTSD current prevalence was significantly higher for *DSM-5* than *ICD-11* (6.7% v. 3.3%, $z = 2.5$, $p = 0.01$). Using *ICD-11* tended to show lower rates of comorbidity with depression and a slightly lower association with disability. *Conclusions*: The diagnostic systems performed in different ways in terms of current prevalence rates and levels of comorbidity with depression, but on other broad key indicators they were relatively similar. There was overlap between those with PTSD diagnosed by *ICD-11* and *DSM-5* but a substantial portion met one but not the other set of criteria. This represents a challenge for research because the phenotype that is studied may be markedly different according to the diagnostic system used.

Regier, D.A., Narrow, W.E., Clarke, D.E., Kraemer, H.C., Kuramoto, S.J., Kuhl, E.A., et al. (2013). **DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses**. *American Journal of Psychiatry*, 170, 59-70. doi:10.1176/appi.ajp.2012.12070999 *Objective*: The *DSM-5* Field Trials were designed to obtain precise (standard error < 0.1) estimates of the intraclass kappa as a measure of the degree to which two clinicians could independently agree on the presence or absence of selected *DSM-5* diagnoses when the same patient was interviewed on

separate occasions, in clinical settings, and evaluated with usual clinical interview methods. *Method*: Eleven academic centers in the United States and Canada were selected, and each was assigned several target diagnoses frequently treated in that setting. Consecutive patients visiting a site during the study were screened and stratified on the basis of *DSM-IV* diagnoses or symptomatic presentations. Patients were randomly assigned to two clinicians for a diagnostic interview; clinicians were blind to any previous diagnosis. All data were entered directly via an Internet-based software system to a secure central server. Detailed research design and statistical methods are presented in an accompanying article. *Results*: There were a total of 15 adult and eight child/adolescent diagnoses for which adequate sample sizes were obtained to report adequately precise estimates of the intraclass kappa. Overall, five diagnoses were in the very good range (kappa=0.60–0.79), nine in the good range (kappa=0.40–0.59), six in the questionable range (kappa=0.20–0.39), and three in the unacceptable range (kappa values < 0.20). Eight diagnoses had insufficient sample sizes to generate precise kappa estimates at any site. *Conclusions*: Most diagnoses adequately tested had good to very good reliability with these representative clinical populations assessed with usual clinical interview methods. Some diagnoses that were revised to encompass a broader spectrum of symptom expression or had a more dimensional approach tested in the good to very good range.

Resick, P.A., Bovin, M.J., Calloway, A.L., Dick, A.M., King, M.W., Mitchell, K.S., et al. (2012). **A critical evaluation of the complex PTSD literature: Implications for *DSM-5***. *Journal of Traumatic Stress*, 25, 241-251. doi:10.1002/jts.21699 Complex PTSD has been proposed as a diagnosis for capturing the diverse clusters of symptoms observed in survivors of prolonged trauma that are outside the current definition of PTSD. Introducing a new diagnosis requires a high standard of evidence, including a clear definition of the disorder, reliable and valid assessment measures, support for convergent and discriminant validity, and incremental validity with respect to implications for treatment planning and outcome. In this article, the extant literature on complex PTSD is reviewed within the framework of construct validity to evaluate the proposed diagnosis on these criteria. Although the efforts in support of complex PTSD have brought much needed attention to limitations in the trauma literature, we conclude that available evidence does not support a new diagnostic category at this time. Some directions for future research are suggested.

Scheeringa, M.S., Myers, L., Putnam, F.W., and Zeanah, C.H. (2012). **Diagnosing PTSD in early childhood: An empirical assessment of four approaches**. *Journal of Traumatic Stress*, 25, 359-367. doi:10.1002/jts.21723 Prior studies have argued that *DSM-IV* criteria were insensitive for diagnosing PTSD in young children. Four diagnostic criteria sets were examined in 284 3- to 6-year-old trauma-exposed children. The *DSM-IV* criteria resulted in significantly fewer cases (13%) compared to an alternative algorithm for young children (PTSD-AA, 45%), the proposed *DSM-5* posttraumatic stress in preschool children (44%), and the *DSM-5* criteria with 2 symptoms that are under consideration by the committee (*DSM-5-UC*, 49%). Using *DSM-IV* as the standard, the misclassification rate was 32% for PTSD-AA, 32% for *DSM-5*, and 37% for *DSM-5-UC*. The proposed criteria sets showed high agreement on the presence

(100%), but low agreement on the absence (58–64%) of diagnoses. The misclassified cases were highly symptomatic, $M = 7$ or more symptoms, and functionally impaired, median = 2 domains impaired. The additional symptoms had little impact. Evidence for convergent validation for the proposed diagnoses was shown with elevations on comorbid disorders and Child Behavior Checklist Total scores compared to a control group ($n = 46$). When stratified by age (3–4 years and 5–6 years), diagnoses were still significantly elevated compared to controls. These findings lend support to a developmental subtype for PTSD.

Stein, D.J., Koenen, K.C., Friedman, M.J., Hill, E., McLaughlin, K.A., Petukhova, M., et al. (2012). **Dissociation in posttraumatic stress disorder: Evidence from the world mental health surveys.** *Biological Psychiatry*, 73, 302–312. doi:10.1016/j.biopsych.2012.08.022

Background: Although the proposal for a dissociative subtype of PTSD in *DSM-5* is supported by considerable clinical and neurobiological evidence, this evidence comes mostly from referred samples in Western countries. Cross-national population epidemiologic surveys were analyzed to evaluate generalizability of the subtype in more diverse samples. **Methods:** Interviews were administered to 25,018 respondents in 16 countries in the World Health Organization World Mental Health Surveys. The Composite International Diagnostic Interview was used to assess 12-month *DSM-IV* PTSD and other common *DSM-IV* disorders. Items from a checklist of past-month nonspecific psychological distress were used to assess dissociative symptoms of depersonalization and derealization. Differences between PTSD with and without these dissociative symptoms were examined across a variety of domains, including index trauma characteristics, prior trauma history, childhood adversity, sociodemographic characteristics, psychiatric comorbidity, functional impairment, and treatment seeking. **Results:** Dissociative symptoms were present in 14.4% of respondents with 12-month *DSM-IV*/Composite International Diagnostic Interview PTSD and did not differ between high and low/middle income countries. Symptoms of dissociation in PTSD were associated with high counts of re-experiencing symptoms and net of these symptom counts with male sex, childhood onset of PTSD, high exposure to prior (to the onset of PTSD) traumatic events and childhood adversities, prior histories of separation anxiety disorder and specific phobia, severe role impairment, and suicidality. **Conclusion:** These results provide community epidemiologic data documenting the value of the dissociative subtype in distinguishing a meaningful proportion of severe and impairing cases of PTSD that have distinct correlates across a diverse set of countries.

Stein, D.J., McLaughlin, K.A., Koenen, K.C., Atwoli, L., Friedman, M.J., Hill, E.D., et al. (2014). **DSM-5 and ICD-11 definitions of posttraumatic stress disorder: Investigating “narrow” and “broad” approaches.** *Depression and Anxiety*, 31, 494–505. doi:10.1002/da.22279 **Background:** The development of the *DSM-5* and *ICD-11* has led to reconsideration of diagnostic criteria for PTSD. The World Mental Health (WMH) surveys allow investigation of the implications of the changing criteria compared to *DSM-IV* and *ICD-10*. **Methods:** WMH surveys in 13 countries asked respondents to enumerate all their lifetime traumatic events (TEs) and randomly selected one TE per respondent for PTSD

assessment. *DSM-IV* and *ICD-10* PTSD were assessed for the 23,936 respondents who reported lifetime TEs in these surveys with the fully structured Composite International Diagnostic Interview (CIDI). *DSM-5* and proposed *ICD-11* criteria were approximated. Associations of the different criteria sets with indicators of clinical severity (distress-impairment, suicidality, comorbid fear-distress disorders, PTSD symptom duration) were examined to investigate the implications of using the different systems. **Results:** A total of 5.6% of respondents met criteria for “broadly defined” PTSD (i.e., full criteria in at least one diagnostic system), with prevalence ranging from 3.0% with *DSM-5* to 4.4% with *ICD-10*. Only one-third of broadly defined cases met criteria in all four systems and another one-third in only one system (narrowly defined cases). Between-system differences in indicators of clinical severity suggest that *ICD-10* criteria are least strict and *DSM-IV* criteria most strict. The more striking result, though, is that significantly elevated indicators of clinical significance were found even for narrowly defined cases for each of the four diagnostic systems. **Conclusions:** These results argue for a broad definition of PTSD defined by any one of the different systems to capture all clinically significant cases of PTSD in future studies.

Weathers, F.W., Marx, B.P., Friedman, M.J., and Schnurr, P.P. (2014). **Posttraumatic stress disorder in DSM-5: New criteria, new measures, and implications for assessment.** *Psychological Injury and Law*, 7, 93–107. doi:10.1007/s12207-014-9191-1 The diagnostic criteria for PTSD were substantially revised for *DSM-5*. This in turn necessitated revision of *DSM*-correspondent assessment measures of PTSD. We describe the various changes to the PTSD diagnostic criteria and the corresponding changes to National Center for PTSD measures. We also discuss the implications of the new criteria for assessment of trauma exposure and PTSD. Although the *DSM-5* version of PTSD departs significantly in some respects from previous versions, we conclude that there is fundamental continuity with the original *DSM-III* conceptualization of PTSD as a chronic, debilitating mental disorder that develops in response to catastrophic life events.

Wolf, E.J., Miller, M.W., Kilpatrick, D., Resnick, H.S., Badour, C.L., Marx, B.P., et al. [in press]. **ICD-11 complex PTSD in US national and Veteran samples: Prevalence and structural associations with PTSD.** *Clinical Psychological Science*. The *ICD-11* is under development and current proposals include major changes to trauma-related psychiatric diagnoses, including a heavily restricted definition of PTSD and the addition of complex PTSD. We aimed to test the postulates of complex PTSD in samples of 2,695 community participants and 323 trauma-exposed military Veterans. Complex PTSD prevalence estimates were 0.6% and 13% in the community and Veteran samples, respectively; one-quarter to one-half of those with PTSD met criteria for complex PTSD. There were no differences in trauma exposure across diagnoses. A factor mixture model with two latent dimensional variables and four latent classes provided the best fit in both samples: classes differed by their level of symptom severity but did not differ as a function of the proposed PTSD vs. complex PTSD diagnoses. These findings should raise concerns about the distinctions between complex PTSD and PTSD proposed for *ICD-11*.

ADDITIONAL CITATIONS

Bensimon, M., Solomon, Z., and Horesh, D. (2013). **The utility of Criterion A under chronic national terror.** *Israeli Journal of Psychiatry and Related Sciences*, 50, 81-83. This is an editorial arguing that both *DSM* and *ICD* “appear to be larger products of the North American and European societies and therefore, may be culturally-biased.” The authors argue that both diagnostic systems focus too much on events and fail to incorporate the everyday realities of individuals in nations such as Israel, Afghanistan, and Iraq who are chronically exposed to terrorist attacks and other traumatic events.

Brewin, C.R. (2013). **“I Wouldn’t Start From Here”—An alternative perspective on PTSD from the ICD-11: Comment on Friedman.** *Journal of Traumatic Stress*, 26, 557-559. doi:10.1002/jts.21843 This is a commentary in response to Friedman (2013a) that eloquently criticizes the *DSM-5* approach while arguing forcefully for the *ICD-11*’s “simple approach to diagnosis that can be used in minimally resourced, non-English-speaking-countries.”

Friedman, M.J. (2013b). **PTSD in the DSM-5: Reply to Brewin (2013), Kilpatrick (2013), and Maercker and Perkonig (2013).** *Journal of Traumatic Stress*, 26, 567-569. doi:10.1002/jts.21847 This is the final article in a special section of the *Journal of Traumatic Stress* (2013), 548-569. It begins with Friedman (2013a) and is followed by three commentaries, Brewin, 2013; Kilpatrick, 2013; and Maercker and Perkonig, 2013 (all cited here). This is a reply to these commentaries.

Galatzer-Levy, I.R., and Bryant, R.A. (2013). **636,120 ways to have posttraumatic stress disorder.** *Perspectives on Psychological Science*, 8, 651-662. doi:10.1177/1745691613504115 Using a binomial equation to elucidate possible symptom combinations, the authors demonstrate *DSM-5*’s “high level of symptom profile heterogeneity.” Whereas there were 79,794 ways to meet PTSD diagnostic criteria in *DSM-IV*, there are now 636,120 combinations in *DSM-5*. They further argue that this heterogeneity indicates “the limitations of *DSM*-based diagnostic entities for classification in research” and elucidates “inherent flaws that are either specific artifacts from the history of the *DSM* or intrinsic to the underlying logic of the *DSM*’s method of classification.”

Kilpatrick, D.G. (2013). **The DSM-5 got PTSD right: Comment on Friedman (2013).** *Journal of Traumatic Stress*, 26, 563-566. doi:10.1002/jts.21844 This is another commentary in response to Friedman (2013a) that strongly argues in favor of the *DSM-5* revisions. Specifically, it states that: 1) placement of PTSD in the new Trauma and Stress-related Disorders category, 2) broadening the PTSD construct, and 3) utilizing the best empirical data, including recent surveys, are all major advances. The author raises concerns about the *ICD-11* approach and suggest that “substantial evidence be required before (its) proposed changes are made.”

Knefel, M., and Lueger-Schuster, B. (2013). **An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse.** *European Journal of Psychotraumatology*, 4, 22608. doi:10.3402/ejpt.v4i0.22608 This article compared “the appropriateness” of *ICD-10* and *ICD-11* with respect to 229 adult survivors of childhood institutional abuse. Prevalence was 52.8% for *ICD-10*; 17% for *ICD-11*; and 38.4% for *ICD-11* + complex PTSD. The prevalence of complex PTSD,

alone, was 21.4% with 40.4% women and 15.8% men meeting criteria for complex PTSD. The authors argue that “(complex) PTSD is a highly relevant classification for individuals with complex trauma history.”

Kupfer, D.J., Kuhl, E.A., and Regier, D.A. (2013). **DSM-5—The future arrived.** *JAMA*, 309, 1691-1692. doi:10.1001/jama.2013.2298 This brief editorial by the leaders of the *DSM-5* process outlines how it differs from the *DSM-IV*. Among these, the focus on diagnosis and clinical care is emphasized along with special attention to the influence of development, gender and culture on the presentation of disorders.

Maercker, A., Brewin, C.R., Bryant, R.A., Cloitre, M., Reed, G.M., van Ommeren, M., et al. (2013). **Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11.** *Lancet*, 381, 1683-1685. doi:10.1016/S0140-6736 This brief editorial is written by *ICD-11*’s working group that addresses mental disorder specifically associated with stress. The article outlines major decisions regarding diagnoses included in this category, such as: 1) a separate diagnostic category for stress-related disorders, 2) attention to the distinction between PTSD and normal “adaptive fear reactions” to ongoing trauma (e.g., continuing conflict, forced migration, and natural disasters), 3) the narrow PTSD diagnostic criteria, restricted to two symptoms from each of three “core elements” (e.g., re-experiencing, avoidance, and arousal), 4) inclusion of complex PTSD, 5) inclusion of Prolonged Grief Disorder, 6) inclusion of Adjustment Disorder, 7) identifying Acute Stress Reaction as a normal reaction to an abnormal event, and 8) emphasizing the advantage of *ICD-11* over *DSM-5* because of greater simplicity, greater clinical utility and greater feasibility in “low resource and humanitarian settings.”

Maercker, A., and Perkonig, A. (2013). **Applying an international perspective in defining PTSD and related disorders: Comment on Friedman (2013).** *Journal of Traumatic Stress*, 26, 560-562. doi:10.1002/jts.21852 This is another commentary to Friedman (2013a) that appeared in the special section of the *Journal of Traumatic Stress*. It essentially reiterates the points made by Maercker, et al. (2013) mentioned previously.

Roberts, A.L., Dohrenwend, B.P., Aiello, A.E., Wright, R.J., Maercker, A., Galea, S., et al. (2012). **The stressor criterion for posttraumatic stress disorder does it matter?** *Journal of Clinical Psychiatry*, 73, e264-e270. doi:10.4088/JCP.11m07054 Used data from the 2009 PTSD diagnostic subsample ($n=3013$) of women from the Nurses’ Health Study II to investigate the relative importance of traumatic events (as defined both in *DSM-III* and *DSM-IV*) as compared to non-traumatic events (e.g., miscarriage, financial problems, legal difficulties, etc.). The major comparison was between women who met all other PTSD diagnostic criteria whether or not they met Criterion A in either *DSM-III* or *DSM-IV*. The authors found that “sequelae of PTSD did not vary systematically with the type of stressful event that initiated PTSD symptoms” (whether it was traumatic or non-traumatic). The authors conclude, given their finding that events not considered traumatic produced PTSD as consequential as PTSD precipitated by a Criterion A event in either *DSM-III* or *DSM-IV*, that “PTSD may be an aberrantly severe but nonspecific stress response syndrome.”

Santiago, P.N., Ursano, R.J., Gray, C.L., Pynoos, R.S., Spiegel, D., Lewis-Fernandez, R. et al. (2013). **A systematic review of PTSD prevalence and trajectories in DSM-5 defined trauma exposed populations: Intentional and non-intentional traumatic events.** *PLOS One*, 8, e59236. doi:10.1371/journal.pone.0059236 The authors reviewed all longitudinal studies on PTSD published between 1998-2010 with regard to clinical trajectories. In general mean prevalence decreased across all studies from 28.8% (at 1 month) to 17.0% (at 12 months). When traumatic events were categorized as "intentional" (e.g., assault, war) or "non-intentional" (e.g., distress, accidents) the PTSD trajectories diverged with a 12 month increase in PTSD prevalence (11.8% to 23.3%) for intentional trauma as compared with a decrease for non-intentional trauma (30.1% to 14.0%). Among those with PTSD 34.8% remit after 3 months, 39.1% have a chronic course and a small fraction (3.5%) of new PTSD cases appear after three months.

Sar, V. (2011). **Developmental trauma, complex PTSD, and the current proposal of DSM-5.** *European Journal of Psychotraumatology*, 2, 5622. doi:10.3402/ejpt.v2i0.5622 This is a very thoughtful review by an international expert on Dissociative Disorders who participated in the DSM-5 process. He commends DSM-5 for setting aside a new category for trauma/stress disorders and argues for inclusion of Dissociative Disorders in that category. He recommends inclusion of a complex PTSD subtype of PTSD in DSM-5 and expresses concerns that the new Dissociative Subtype may be too narrow because it excludes some of the mood and interpersonal symptoms of complex PTSD. "In fact a broader understanding of dissociation would not only support new empirical research and novel treatment modalities on trauma-related disorders, but it would also facilitate formulation of new theoretical paradigms necessary to provide integrated solutions for conceptual dilemmas of the field." Other topics considered are Borderline Personality Disorder and the clinical expression of developmental trauma.

Young, G. (2014). **PTSD, endophenotypes, the RDoC, and the DSM-5.** *Psychological Injury and Law*, 7, 75-91. doi:10.1007/s12207-014-9187-x This paper examines endophenotypes (e.g., measurable aspects in the pathway between genotype and disease) in relation to the NIMH RDoC and the DSM-5. The author proposes "a model for the study of endophenotypes that respects multiple influences on the etiology of psychiatric disorder, including psychosocial, without sacrificing the goal of finding causal links from genes to behavior." He concludes that it is currently premature to seek individual biomarkers for PTSD given the current state of the field, but that we should all keep up to date on the future breakthroughs since research is burgeoning.

Young, G., Lareau, C., and Pierre, B. (2014). **One quintillion ways to have PTSD comorbidity: Recommendations for the disordered DSM-5.** *Psychological Injury and Law*, 7, 61-74. doi:10.1007/s12207-014-9186-y This is an elaboration on Galatzer-Levy and Bryant (2013-see above) which considers the number of the ways to have PTSD and its most common comorbid conditions (e.g., major depressive disorder, chronic pain, neurocognitive disorder due to traumatic brain injury, alcohol use disorder and trauma-related/exacerbated premorbid personality disorder such as borderline personality disorder). They calculate that "over one quintillion

combinations are possible." They recommend prioritizing PTSD and comorbidities as primary (e.g., unique marker), secondary (e.g., core essential) and tertiary (e.g., common cross-diagnostic). They assert that such prioritization "might help make the next version of the DSM more clinically useful both to clinicians and to court."

Zoellner, L.A., Bedard-Gilligan, M.A., Jun, J.J., Marks, L.H., and Garcia, N.M. (2013). **The evolving construct of posttraumatic stress disorder (PTSD): DMS-5 criteria changes and legal implications.** *Psychology Injury and the Law*, 6, 277-289. doi:10.1007/s12207-013-9175-6 This editorial considers the forensic implications of the DSM-5 criteria. "The changes ... have the potential to increase the heterogeneity of individuals receiving a PTSD diagnosis by altering what qualifies as a traumatic event and by adding symptoms commonly occurring in other disorders ... Legal implications of these changes include continued confusion regarding what constitutes a traumatic stressor, difficulties with different diagnosis, increased ease in malingering, and improper linking of symptoms to causes of behavior."

Zoellner, L.A., Rothbaum, B.O., and Feeny, N.C. (2011). **PTSD not an anxiety disorder? DSM committee proposal turns back the hands of time.** *Depression and Anxiety*, 28, 853-856. doi:10.1002/da.20899 This editorial is strongly critical of the DSM-5's removal of PTSD from the Anxiety Disorder category. Arguments are: 1) fear is a critical construct for the development of PTSD, 2) treating trauma-related fear and avoidance is central to PTSD, 3) a lack of evidence exists for a stressor meta-construct separate from the Anxiety Disorders, and 4) this shift ignores cumulative evidence and moves the field backward.