# PTSD: An Elusive Definition

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ABSTRACT

The Global War on Terrorism became the longest standing conflict in United States military history on June 7, 2010. It is estimated that 1.64 million U.S. troops have been deployed in support of Operation Enduring Freedom and Operation Iraqi Freedom (p xix).1 Both conflicts have produced high numbers of casualties as the result of ground combat. The amount of casualties though has been relatively low compared to other conflicts. Some of this can be attributed to the advances in body armor and emergency medicine that allow many servicemembers to survive conditions that previously led to death. Conversely, surviving these situations leaves those same members with memories that are psychologically difficult to live with and cause chronic difficulties. Unlike an amputee, or the victim of severe burns where the signs and symptoms of their injuries are obvious, patients with psychological disorders can have a range of signs and symptoms common in many other mental disorders, making it difficult to diagnose and treat Soldiers suffering from Post-traumatic Stress Disorder (PTSD).

In America today we most commonly associate diagnosed PTSD patients with the men and women who served in military conflict. This would be an accurate assumption as those military sufferers pressured the military and medical establishments to recognize the disorder. It was not until 1980 that the term PTSD was formally recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM)—III (the DSM is recognized by the American Medical Association [AMA] and the American Psychiatric Association [APA]). Since that time, a multitude of research has been done towards understanding the causes, characteristics, and pathology of the illness.

Further understanding of the psychological effects of combat has led to an increase in cases of psychiatric illnesses being diagnosed. Despite intentions for pullout in 2014, there will still be many combat troops around the world for years to come, and many still being subject to life threatening situations. Some scholars, doctors, and government officials speculate that in the future the psycho-trauma of war will produce the largest number of casualties receiving medical treatments. This raises the concern that diagnosed cases of PTSD could become epidemic among veterans; however, this epidemic will largely be a consequence of over diagnosis on account of the current definition of PTSD in DSM– IV-TR.[2]

This concern has not gone unnoticed and today there are a range of issues under criticism and review regarding the issue of diagnosing troops with PTSD. There have been countless papers, studies and articles proposing what changes need to be made to the diagnostic criteria for PTSD. The issues in question include, the overlapping non-specific symptoms it has with many other common mental disorders, how its pathology follows stress reactions to normal events (p. 366)[3] and the broad definition of Criterion A as stated in the DSM–1V-TR (p. 232).[4] Criterion A as stated in the DSM-IV-TR reads:

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 self or others.
2. The person's response involved intense fear, helplessness, or horror (p. 467).[2]

To understand these issues, one must first understand some of the history involved in the debate and how the diagnostic criteria for PTSD has evolved.

Over the years, the DoD has made efforts to improve evaluation, diagnosis, and recording of psychiatric casualties. However, the changing definitions and measures of combat-related mental health conditions make it difficult to compare incidence rates across different conflicts (p. 4).[1] To screen for post-traumatic stress symptoms, the military uses the Post-traumatic Symptom Checklist—Military Version, an instrument that contains 17 symptom items keyed directly to the DSM-IV-TR (p. 92).[1]

The DSM is currently under revision and a new manual, DSM-V, will be unveiled in May 2013, and any changes

to PTSD will have implications in how people are diagnosed in the future. As a result there have been countless papers, studies, and articles proposing what changes need to be made to the diagnostic criteria for PTSD. Advocates for tightening the definition of PTSD point primarily to faults in the current construct of Criterion A, which includes ambiguous terms that can lead to the inclusion of indirect exposure and to over diagnosis (p. 465).[5]

When examining Criteria A1, the wording is problematic in respect to the "mode" of exposure. While "experienced, witnessed, or confronted" all could qualify as appropriate methods of exposure, they are vulnerable to over application (p. 236).[6] With comparing "experienced" and "confronted", very diverse experiences to traumatic events could theoretically produce the same result. With regard to original conceptualization of PTSD, a diagnosed case as a result of a "confronted" exposure can reasonably be seen as a false result. Robert McNally, a psychology professor at Harvard, refers to these instances as "conceptual bracket creep" (p. 231).[4] As an example, McNally argues that the secondhand experience of having been confronted with a traumatic experience, by way of overhearing the events is "qualitatively different" from the first hand experience of being ambushed by an improvised explosive device (p. 231).[4]

Robert L. Spitzer of Columbia University argues that cases of PTSD being diagnosed on the basis of being confronted with a traumatic event are "just an exacerbation of preexisting mood, anxiety or personality disorders that appear like PTSD" (p. 236).[6] Spitzer and his colleagues proposed the solution to the problem is to remove the vague "confronted with" from the diagnosis.[6] Additionally, by modifying "experienced" to say "directly experienced" the amount of cases that before were deemed relevant are reduced by subtracting patients who are suffering from a similar mental disorder, or are showing normal signs of reaction to stress (p. 231).[4]

These changes are not seeking to exclude people who are potentially suffering from PTSD, but simply attempting to differentiate true PTSD sufferers (p. 236).[6] This is important because with the current definition of Criterion A, exposure is unavoidable in the deployed environment. The nature of military operations qualifies the member for further investigation because the broad traumatic criterion can always be attributed to the cause of distress, regardless if it is the trigger for the symptoms. The minor grammatical under sight in A1 is part of a larger debate of whether Criterion A, exposure to a traumatic stressor, needs to be a qualifying criteria.

PTSD is unique in that it requires a specific etiology (traumatic event), which is uncommon in other mental health disorders. This exists because the original intent of the diagnosis sought to establish a disorder for military members suffering symptoms that at the time could not be understood. Be that as it may, this uniqueness could result in any recollection of a traumatic event joined with the symptoms listed in PTSD's diagnostic criteria (Criterion B-F) being a positive diagnosis. This is problematic because the possibility remains that there is another underlying disorder (depression, anxiety, etc.) that existed prior to the traumatic event that is being overlooked because of the associated commonality of PTSD with any mental illness suffered by military members.

A persons reaction to a traumatic event can be interpreted incorrectly because PTSD includes too many general overlapping symptoms with other disorders, and normal responses to negative events (p. 237).[6] It has been suggested that Criterion A be eliminated all together, thus removing any controversy surrounding the issue of its definition (p. 370).[3] Advocates of this theory require that the other defining criterion must be reduced to those symptoms that have proven more diagnostic to positive cases of PTSD rather than other associated disorders. Generally this is what most experts agree should take place regardless of the presence of Criterion A in the definition. According to Brewin et al., without the required etiology, two problems with Criterion A would be alleviated. Defining which events qualify as traumatic and patient's recollection of events would less directly affect the diagnosis by allowing pure analysis of the symptoms. Allowing doctors to focus on patient symptoms, without being persuaded of PTSD based on the existence of a traumatic event, would place more emphasis on screening the symptoms. This could lead to more accurate diagnosis and the most appropriate treatment, but negatively leaves the diagnosis again open to criterion creep (p. 370).[3]

Research to narrow the defining criteria has been intriguing, but unfruitful in terms of a common outcome. The 17 symptoms that populate the Post-traumatic symptom Military checklist are listed in Criterion B-D in the DSM–IV-TR. Symptoms are divided into re-experiencing (B), avoidance/numbing (C), and increased arousal (D), commonly referred to as symptom clusters (DSM 468).[2] Experts are split on which symptoms or symptom clusters are most linked to true cases of PTSD. The difficulty being that many of these symptoms are reported in a wide range of psychiatric illnesses and the subjective nature in the individuality of every patient. The significance and importance in determining a core list of symptoms is that it will produce a higher degree of reliability in diagnosis. Instead of a list of 17 symptoms, which contain many overlapping symptoms, experts agree that 4–6 core specific symptoms to the illness would perform as well (p. 369).[3]

Recurrent themes in the research point to symptom cluster C as being the most unique and recurrent to PTSD. Criterion B and D contain symptoms often recurrent in other disorders and less indicative of PTSD thus providing little clinical significance in diagnosis (p. 38).[7] Studies have shown that symptoms in Criterion C are less likely to be met than those in B & D, and that re-experiencing and increased arousal are normal stress reactions and do not provide accuracy with respect to the traumatic event (p. 237).[6] Dr. Carol North concludes, "Thus, while the relatively common group B & D symptoms signify distress, the less prevalent group C cluster serves as a marker of psychopathology" (p. 38).[7]

The reason that Criterion C is receiving the most acclaim as an indicator is because it has shown a higher threshold than B & D (p. 38).[7] A higher threshold means that the symptoms produce the psychological or physiological effect most indicative of the disorder in true cases. Since non-disordered individuals recollections of a traumatic event will trigger increased arousal and distress in re-experiencing, the definitions of these criteria must be re-written to capture their essence in regard to the pathology of PTSD (p. 238).[6] Writers of the new DSM-V should reduce the clusters to indicate the symptoms most specific to the pathology of PTSD, leaving the others to use in order to determine a differential diagnosis. Also, symptoms should be rewritten adding words to express more excessive and intense psychological and physiological responses as is typical in true cases of PTSD.

When studies were conducted with the victims of the Oklahoma City bombing, it was shown that 94% of directly exposed survivors who met Criterion C also met the criteria for PTSD, opposed to the zero cases that were found in those who did not fulfill the criteria (p. 38).[7] These statistics make a strong case for Criterion C remaining in the current definition of symptoms, because it deals with directly exposed survivors. The key being that they directly experienced the traumatic event. The patient sample and type of event provide a good example for the military to look towards with respect to the screening process, and provide a good base for a more specific checklist of symptoms to combat over diagnosis.

Therefore, supporting Criterion C as the major indicator of PTSD requires that criterion A remain in the diagnosis, especially in the military setting. Evaluating the symptoms without association to the traumatic event tears away the specificity that makes them accurate (p. 38).[7] Maintaining Criterion A also deters from the criterion creep because the overlapping PTSD symptoms that would result from "normal" deployment stress (e.g., relationship and financial problems) would be excluded from the diagnosis (p. 3).[8]

For the inclusion of the etiology in the diagnosis, Spitzer points out various other research studies that looked at the relationship between the absence of a traumatic event with experienced symptoms. The subjects in these studies were individuals under stress, but had not experienced a traumatic event, nor had a history of another mental disorder. Results of the studies reported subjects experiencing PTSD-qualifying symptoms (p. 237).[6] This is mentioned to emphasize why Criterion A and more defined symptoms need to remain in the future diagnosis. Criterion A and its relationship with symptoms listed in Criterion C represent the two most essential elements towards the future definition. This is based on the fact that Criterion C has shown the most accuracy with first time positive diagnoses because of specificity to the pathology of PTSD, while in conjunction with Criterion A avoids the risk of false diagnosis by requiring a relationship between symptoms and a specific traumatic event.

False diagnosis is without question detrimental to the long-term mental health of the individual Soldier. Epidemic over diagnosis as a result of false diagnosis could prove to have very extreme social and financial consequences for the military and general public. Currently the military estimates 300,000 people suffer with PTSD or major depression (p. xxi).[1] The major costs of short- and long-term mental healthcare for that many Soldiers and future cases is in the billions of dollars. This does not include the unknown costs linked to historical problems that follow Soldiers such as: lost productivity at work, lower probability of finding steady work, secondary illnesses steaming from substance abuse issues, homelessness, and suicide (p. 176).[1] This information is only presented to emphasize how critical the restructuring of the diagnosis will be in the DSM-V. True PTSD sufferers will likely exhibit the behaviors mentioned above, but falsely diagnosed will also suffer similar hardships because they will be subject to inappropriate treatment that will exacerbate the symptoms of their underlying disorder.

PTSD is proven to be a growing problem and currently the outlook for future veterans is not promising. To avoid over diagnosis in the future the three major issues surrounding the PTSD diagnosis in the DSM-IV-TR must be addressed and altered in DSM-V. First, the broad definition of Criterion A must be properly articulated so that the mode of exposure is distinct and fulfills the intent of the disorder to avoid conceptual bracket creep. Second, the overlapping symptoms that make up the diagnostic criteria for PTSD will need to be tailored down to include only those that past research has shown produce higher thresholds that lead to positive diagnoses. Third, the normal reactions to stress that are experienced by all people must not be included in the normal pathology of PTSD.

As our military conflicts continue and the date of the new DSM draws closer, the psychiatric professionals most familiar with PTSD must fervently continue to research the disorder and reach consensus on its future. Further research needs to focus on the screening process for PTSD and determining a more specific set of non-overlapping PTSD symptoms (p. 371).[9] With the intent being to better understand how this disorder effects purely combat related cases of PTSD, case studies must be done that separate the modes of exposure currently detailed in Criterion A. By doing this we can better analyze how individualized training in Soldiers (infantryman vs. communications specialist) is affecting their vulnerability and resiliency to traumatic events (p. 371).[9]

Despite changes to PTSD that may occur in DSM-V, responsibility still largely lies on the medical practitioner's assessing these veterans to analyze the symptoms systematically and with great discretion. When dealing with matters as sensitive as psychological disorders and the cultural stigma that results from their diagnosis, finding solutions to problems that please everyone is difficult. While there are many sufferers of PTSD in the civilian world, the military must ensure that the diagnosis works within the confines of its ranks. Finding the correct specificity with the appropriate sensitivity in order to provide an absolute solution to diagnosis will likely never be accomplished. Mental disorders are subject to individuality. The impact events have on the individual Soldier will not always yield the same result, and that is the complicated nature of the disorder.

### Note

Criterion B, C, and D as stated in the DSM-IV-TR on p. 468:

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   2. recurrent distressing dreams of the event
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
   4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hyper-vigilance
   5. exaggerated startle response

### Proposed DSM-V Criterion:

A. Exposure to actual or threatened a) death, b) serious injury, or c) sexual violation, in one or more of the following ways:
   1. directly experiencing the traumatic event(s)
   2. witnessing, in person, the traumatic event(s) as they occurred to others
   3. learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death must have been violent or accidental
   4. experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s) (Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.)
   2. recurrent distressing dreams in which the content or affect of the dream is related to

the event(s) (Note: In children, there may be frightening dreams without recognizable content.)
3. dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) are recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. (Note: In children, trauma-specific reenactment may occur in play.)
4. intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. marked physiological reactions to reminders of the traumatic event(s)

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by avoidance or efforts to avoid one or more of the following:
1. distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. external reminders (i.e., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about, or that are closely associated with, the traumatic event(s)

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred), as evidenced by two or more of the following:
1. inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia that is not due to head injury, alcohol, or drugs)
2. persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous"). (Alternatively, this might be expressed as, e.g., "I've lost my soul forever," or "My whole nervous system is permanently ruined").
3. persistent, distorted blame of self or others about the cause or consequences of the traumatic event(s)
4. persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
5. markedly diminished interest or participation in significant activities
6. feelings of detachment or estrangement from others
7. persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:
1. irritable or aggressive behavior
2. reckless or self-destructive behavior
3. hypervigilance
4. exaggerated startle response
5. problems with concentration
6. sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributed to the direct physiological effects of a substance (e.g., medication, drugs, or alcohol) or another medical condition (e.g. traumatic brain injury).

Specify if:
With Delayed Expression: if the diagnostic threshold is not exceeded until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

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