PTSD in the *DSM-5*

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Summary of Changes in *DSM 5*

- PTSD no longer an anxiety disorder
- A new category of trauma and stressor-related disorders
- Four phenotypes that may have treatment implications
  - Fear-based anxiety
  - Anhedonic/dysphoric
  - Externalizing
  - Dissociative

Summary of Changes in *DSM 5*

- Criterion A: Definition of trauma “exposure to actual or threatened death, serious injury, or sexual violence.” Can be actual victim or witness.
Summary of Changes in DSM 5

- Four symptom clusters (rather than 3)
  - B. Re-experiencing
    - now includes dissociative reactions
  - C. Numbing
  - D. Avoidance
  - E. Hyperarousal and hypervigilance

Summary of Changes in DSM 5

- All 17 DSM-IV B to D symptoms retained
  - But clarified or re-framed
- Three new symptoms added for a total of 20
- Expansion that includes symptoms that are a closer fit to or more inclusive of Complex PTSD
  - Attention to identity disturbance
  - Attention to additional emotions

A Exposure to a traumatic event (A1)
1. Directly experiencing the event(s)
2. Witnessing the event(s)
3. Learning that the event(s) occurred to a close relative or close friend
4. Experiencing repeated or extreme exposure to aversive details of the event(s)

A2 Eliminated in DSM-5 (i.e., fear, helplessness, or horror)
B Intrusion symptoms
1. Intrusive distressing memories of the traumatic event(s) (DSM-IV B1)
2. Recurrent distressing trauma-related dreams (DSM-IV B2)
3. Dissociative reactions (e.g., flashbacks) (DSM-IV B3)
4. Intense psychological distress when exposed to traumatic reminders (DSM-IV B4)
5. Marked physiological reactions

C Avoidance symptoms
1. Persistent avoidance of thoughts and memories (DSM-IV C1)
2. Persistent avoidance of external reminders (DSM-IV C2)

D Negative alterations in cognitions and mood
1. Dissociative amnesia of the traumatic event(s) (DSM-IV C3)
2. Persistent negative expectations (DSM-IV C7)
3. Persistent distorted blame of self or others about the traumatic event(s) (new)
4. Persistent negative emotional state (new)
5. Diminished interest or participation in significant activities (DSM-IV C4)
6. Feeling of detachment or estrangement from others (DSM-IV C5)
7. Persistent inability to experience positive emotions (DSM-IV C6)
E Alterations in arousal and reactivity
1. Irritable behavior or angry outbursts (DSM-IV D2)
2. Reckless or self-destructive behavior (new)
3. Hypervigilance (DSM-IV D4)
4. Exaggerated startle response (DSM-IV D5)
5. Problems with concentration (DSM-IV D3)
6. Sleep disturbance (DSM-IV D1)

To Make the PTSD Diagnosis
- Criterion A
  - Cluster B, 5 intrusive sx
    - endorse at least 1
  - Cluster C, 2 avoidance sx
    - endorse at least 1
  - Cluster D, 7 negative mood & cognition sx
    - endorse at least 2
  - Cluster E, 6 arousal/reactivity sx
    - endorse at least 2

1. Specify if: dissociative subtype (full PTSD plus derealization or depersonalization)
2. Specify if: preschool subtype
   (1 B and 2 E, but only 1 C or D symptoms are needed)
3. Specify if: with delayed expression of symptoms
Summary of Changes in DSM 5

- Two new sub-types:
  - Dissociative
  - Preschool
- Conservative approach taken
- Dissociative Sub-Type: most similar to Complex PTSD
  - Includes depersonalization and derealization
  - Additional research needed to substantiate a freestanding diagnosis or a subtype of complex PTSD
  - In 25% of pts. With increased comorbidity, more severity of PTSD (Lanius, 2013)

Summary of Changes in DSM 5

- Preschool Sub-type (up to age 6)
  - Promotes consideration of developmental modulation of reactions to trauma and expression of PTSD
  - Ages 6-12 expression now under investigation

The Trauma/Stress-Related and Dissociative Disorders Sub-Work Group consisted of Roberto Lewis-Fernandez, David Spiegel, Robert Ursano, Robert Pynoos, and Matthew Friedman (chair).

A separate Child and Adolescent Disorders Work Group chaired by Daniel Pine and including Charles Zeanah (who was the expert on child trauma) worked with us on developmental diagnostic issues.

Katherine Phillips participated fully in the activities of all three anxiety disorders’ sub-work groups.
"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, 2013, p. 548).

*Past chair of the APA sub-work group that developed these criteria

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PTSD in the ICD-11

...feasible to follow previous recommendations ... to reduce the number of qualifying symptoms and simply require evidence for the combination of one symptom of reexperiencing 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 (Brewin, 2013, JTS, p. 559).

- No "Criterion A" as in the DSM

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Complex PTSD in the ICD-11

- Symptom pattern
  - Core symptoms of PTSD
  - Persistent and pervasive impairments in each of the following
    - Affective functioning: Affect dysregulation, heightened emotional reactivity, violent outbursts, tendency towards dissociative states when under stress
    - Self functioning: Persistent beliefs about oneself as diminished, defeated or worthless; pervasive feelings of shame, guilt.
    - Relational functioning: Difficulties in sustaining relationships or feeling close to others
Psychobiological Studies

- Lanius et al. research findings about differences between dissociative and hyperaroused sub-types of PTSD and associated brain differences
- Richard Bryant research about brain differences in patients with PTSD and Complex PTSD

Research comparing the DSM-5-based and ICD-11-based criteria for PTSD is urgently needed. The two diagnostic systems may result in real differences in who receives a diagnosis (Friedman, JTS, 2013).

Future Directions

- Longitudinal studies to examine posttraumatic and dissociative symptoms over time
- Further study of physiological differences and biomarkers associated with complex PTSD and dissociation
- Examine the relationship of the dissociative sub-type to Complex PTSD as proposed in the ICD-11
- Compare DSM 5 to ICD-11 criteria