

Review

Classification of posttraumatic stress disorder and its evolution in Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria

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The purpose of this review is to provide an historical understanding of post-traumatic stress disorder. The concept of trauma is changing drastically in every publication or revision of Diagnostic and Statistical Manual of Mental Disorders. The underlying dimensions of trauma are also under constant consideration. Thus, the paper would provide some historical background of trauma nomenclature. This will enable the researcher to think of future diagnosis and differential diagnosis of traumatic syndromes. Posttraumatic stress disorder has been out there as back as human history. However, the recognition of traumatic symptoms on people's lives and mental health has been recently recognized. Even though non-governmental organizations and civic society drew attention of this issue for a long time, the legal and administrative bodies were reluctant to take action and recognize the effects of traumatic experiences on people's life.

Key words: Post traumatic stress disorder, statistical manual, mental disorders, nomenclature, post-traumatic stress disorder (PTSD), historical evaluation of PTSD.

INTRODUCTION

Obviously wars have adversarial effects on everybody's life whether they have been in combat or not. Vietnam war is the hallmark for the recognition of traumatic stress on public and civic sphere. Many veterans have adjustment, marital, drug and alcohol, and occupational problems after the war. Thus, following WW-II, the American Psychiatric Association (APA) published the first of the series of Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The DSM-I used the name "Gross Stress Reactions" in reference to stress-related experiences. Gross Stress Reactions referred to a reaction to extreme stress, such as war, disasters, fires,

earthquakes or explosions (Berthold and Carlier, 1992). By definition, the disorder was described as acute stress, and in the absence of stress it was suggested to look for another diagnosis. In DSM-I and DSM-II, the categories of gross stress reaction and transient situational disturbance, respectively, were used to describe acute symptomatic distress following adversity; whereas more prolonged disorders were conceptualized as being anxiety or depressive symptoms (Yehuda and McFarlane, 1995).

The APA published the second DSM in 1968. DSM-II did not include a specific category for stress related

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reactions. However, it recognized that extreme stress could be followed by mental health problems in that it included the diagnostic category of "Temporary Situational Disorder" (O'Brien, 1998). This category was intended to define reactions to unusual stress caused by anything from unwanted pregnancy to a death sentence (Berthold and Carlier, 1992). However, such stress was seen as a self-limiting condition. It was felt that chronic problems occurred only in those with severe premorbid personality disturbances. In those cases, the condition was solidified into a recognizable psychiatric disorder.

VIETNAM ERA AND CONTRIBUTIONS OF WAR

The Vietnam War was definitely a turning point in the history of posttraumatic stress disorder. Post-traumatic Stress Disorder (PTSD) was not a particularly popular topic before Vietnam. Even though the APA had published two DSM manuals and did some modification in the definition of extreme stress and traumatic experiences, literature provides very few studies concerning traumatic stress. In early studies, it was reported that Vietnam had low rates of psychiatric casualties (Jones, 1967). However, later studies suggested that 300,000 to 700,000 or more of the 3,000,000 who served in Vietnam had PTSD (O'Brien, 1998). Some studies had focused on Holocaust survivors and women who had suffered violent sexual crimes, but the Vietnam War was the essential element in the development of the diagnosis of PTSD.

The Vietnam War is said to have been different from other wars. It was unpopular, prolonged, low intensity, distant, a guerilla conflict, and lost by Americans. Moreover, during the era, peace was socially more accepted than war. Thus, Vietnam veterans were not welcomed as heroes. Gradually, a database was developed and small-scale studies were conducted, especially single case studies, which were done in many hospitals and research centers. Then, Vietnam began to be associated with social problems, poor integration in society, criminal behavior, mental health problems, divorce, and substance and alcohol abuse (O'Brien, 1998). Despite the much lower rates of acute illness, there were apparently much higher rates of chronic illness such as PTSD in veterans after they left the army. In line with that, a series of books, films, television programs, and newspaper articles, emphasized the plight of veterans who had been marginalized and socially handicapped. There were some attempts to get government involvement in this new issue.

However, Congress constantly refused to fund any rehabilitation, intervention or prevention programs for Vietnam veterans. Nonetheless, finally in 1979 Congress agreed to subsidize services for Vietnam veterans with readjustment problems (Kelly, 1985). These adjustment problems were described as "a low-grade motivational and behavioral impairment with a victim's overall ability to

cope reasonably with his daily life." A readjustment problem does not usually amount to a definable psychiatric illness. However, with new funding, new hospital and treatment centers opened, more professionals were hired, and large scale data were collected. Therefore, most of today's current knowledge about the etiology, prevalence, and treatment is based widely on Vietnam War veteran studies. The Vietnam phenomenon led the way to defining a new classification in 1980, when PTSD was officially identified for the first time (APA, 1980).

Historical, political, and social forces have played a major role in the acceptance of the idea of trauma as a cause of the specific symptoms of PTSD (Yehuda and McFarlane, 1995). Political turbulence, atrocities, and ethnic genocide as well as civil and guerilla wars in different parts of the world in the late 70's and early 80's, (for example, communist oppression in Cambodia, Vietnam, guerilla wars in Latin America, and civil war in Lebanon, and Revolution in Iran) caused many to be persecuted, tortured and exiled from their own homeland and millions of refugees sought a safe haven in Western Europe and North America. Studies of political persecution and big tides of exodus shed more light on our understanding of the dynamics of trauma and its long-term effects. Thus, the formulation of PTSD as a normative and adaptive response to trauma in the DSM-III addressed social and political issues as well as mental health issues. From a social and political perspective, PTSD as a concept has done much to assist in the recognition of the rights and needs of victims who have been stigmatized, misunderstood, or ignored by the mental health field.

The APA acknowledged the role of trauma in the etiology of certain psychological symptoms in 1980. Before that time, traumatic symptoms (hysteria) were seen as an individual pathology, rather than caused by external factors. In 1980, the construct of PTSD was incorporated into the DSM-III, Diagnostic and Statistical Manual of Mental Disorders, and there was a move away from looking at premorbid vulnerability as the contributing factor. At the same time, the construct of "hysteria" disappeared from the DSM system, and was divided into several different mental disorders (van der Kolk et al., 1996b).

The introduction of the new diagnosis PTSD was the recognition of the psychic consequences of war, especially as experienced by Vietnam veterans (Berthold and Carlier, 1992). The early studies reported a lot of similar symptoms and emotional and behavioral reactions to disaster, war, and trauma experience. However, it was not until 1980 that the diagnostic category of PTSD was officially introduced in the DSM-III American Psychiatric Association (APA) because evidence gained from empirical studies suggested that the impairment following extreme adversity is etiologically and phenomenologically different from what it was originally thought to be. With

the DSM-III (1980), PTSD was classified as an anxiety disorder with social, emotional and behavioral dimensions (Foy et al., 1987). When the diagnosis of PTSD was first introduced in 1980, 12 symptoms were specified, clustered into three groups: Criterion Set B (3 re-experiencing symptoms; that is, recurrent and intrusive recollections of the traumatic event, such as flashbacks and nightmares), set C (3 symptoms representing numbing of responsiveness; restricted affect) and Set D (6 other symptoms, including symptoms of hyperarousal, avoidance of trauma-related stimuli, and guilt about surviving the trauma). An individual must present at least one re-experiencing, three avoidance, and two arousal symptoms to be diagnosed with PTSD (Taylor et al., 1998). DSM-III is the first classification which considered the role of external environmental elements as triggering factors.

However, some important issues remained unresolved (McFarlane, 1988b). The first problem was that the reliability of DSM-III was established in outpatient settings. This led to some problems in discriminating between war and disaster-related experiences. Even though the DSM-III was published sometime after the Vietnam War, the initial reports showed a very low prevalence of psychiatric disorders during the war. In the following years, thousands of veterans flooded into hospitals and became involved in many social, marital, and criminal behaviors, drug addiction, and other psychiatric disorders. Then the delayed recognition of substantial psychiatric morbidity gained more attention and changed the clinician's understanding of the early phenomenology of PTSD and other disorders. On the other hand, many veterans demonstrated significant achievements and adaptations in their private as well as social life (Breslau and Brenner, 1987). Secondly, other studies (Saigh, 1991; Solomon and Canino, 1990; Yehuda and McFarlane, 1995) reported that a majority of patients with PTSD diagnosis had some other concurrent psychiatric diagnosis. These comorbidity issues had been cited in many resources and gave way to consider a new classification. Most studies assess PTSD reports either in terms of rates of full-blown diagnosis, or else in terms of undefined partial or subclinical levels (Solomon et al., 1989). Criteria C and D are misplaced and, in fact, are symptoms of other disorders such as depression or anxiety, and therefore resulted in artificially high rates of co-morbidity diagnoses. Breslau and Brenner (1987) argued that the DSM-III diagnosis was based on face validity (expert consensus). They further claimed that PTSD overlaps with other disorders, especially with generalized anxiety disorders, phobia, and depression. In defining the symptoms of PTSD, there is a clear overlap with psychoanalytically defined anxiety neurotic symptoms, such as depersonalization, de-realization, obsession and compulsions, histrionic behavior, and mood disturbance. Both the theoretical connection with neurosis through the re-experiencing of the trauma and

the phenomenological similarity in clinical symptoms make it clear that DSM-III PTSD is in fact a special case of the psychoanalytic construct of neurosis in which affective components are especially intense (Breslau and Brenner, 1987). The suggested new criteria included a) existence of a severe stressor, and b) the re-experiencing of the trauma. Re-experiencing of the trauma does not occur with other disorders. Similarly, a connection was seen between the stressor and an adjustment disorder. However, adjustment disorder was not defined in DSM-III as a distinctive category. Common significant distress or the stress "outside of usual human experience" did not provide a definitive rule in determining PTSD. For example, common stressful experiences did not qualify a person for PTSD, but chronic illness, man-made disasters, and natural disasters did qualify an individual for PTSD diagnosis. Solomon and Canino (1990) provided empirical findings and argued that common stressful events such as moving, money problems, breaking-up with a best friend, involuntarily taking someone into the home, and similar incidents are more closely related to PTSD than life events are. Their results suggested that the definition of trauma as "outside the range of usual human experience" is inappropriate. Because some problems attached to DSM-III criteria and children's reactions were not specifically addressed, some researchers (Galante and Foa, 1986; McFarlane et al., 1987) continued to use instruments that measure aggression, school problems, depression etc. in order to identify emotional problems. Rutter Behavioral Questionnaires and Beck Depression Inventories (both instruments had parents' and teachers' forms available) were commonly used to assess "posttraumatic phenomena" (McFarlane et al., 1987) reactions in children.

Then in the following years the DSM-III was revised again (APA, 1987) and the symptom list was modified again and expanded to 17 symptoms. Set B was increased to 5 re-experiencing symptoms. Set C was increased to 7 symptoms by including avoidance and numbing symptoms, and set D was refined to include 5 symptoms of hyperarousal. The symptom regarding survivor guilt was dropped from the list. Moreover, the DSM -III-R classification did not distinguish between acute and chronic PTSD (Foy et al., 1987).

Thus far, it is clear how often emphasis was put on the temporary or reactive aspects of PTSD while extending the stressor group to include a much broader spectrum of undesired experiences. Discussion about the reactive and temporary nature of the "stress reaction" became a major argument after 1980. The duration of time of a reaction to a stress was being argued. Finally, in DSM-III-R, duration of the emotional state of discomfort of at least one month was required, but the general opinion was that the one month stipulation was purely arbitrary (Berthold and Carlier, 1992). The symptoms in the DSM-III-R were retained in the DSM-IV (American Psychiatric Association,

1994), with the only exception being that one of the symptoms from Set D was reallocated to set B. One of the most significant changes was to acknowledge that children might react to a traumatic event with disorganized and agitated behavior (APA, 1994). Previous classical studies cited some regressive behavioral patterns as symptoms of stress. Conversely, the DSM-IV discarded the criterion of "loss of newly learned skills." Palmer (2001) brought up another criticism, saying that although the DSM-IV is being used extensively by mental health professionals as a basis for diagnostic and treatment purposes, the construct of disorders within the DSM-IV has not been empirically validated.

The most current version of the DSM is the Fourth Edition, Text Revision (DSM-IV-TR; 2000), published in June 2000 by the American Psychiatric Association. Similar symptoms are employed in their revised edition as well. PTSD is officially classified as an anxiety disorder, but some have argued that it fits more closely with the dissociative disorders, and others feel it belongs by itself. While some consider PTSD the pure and only result of trauma, some studies present various symptoms as related to this theme. Depression, anxiety, and dissociation are three disorders that may sometimes arise after the traumatic experience. Dissociation is a fairly normal coping strategy in the face of overwhelming stress, but extreme dissociative tendencies may be pathological. The current understanding of dissociation with regard to PTSD is very close to Janet (1911)'s explanations. In addition, some researchers have also reported somatoform reactions. There has also been discussion over differential diagnoses for simple vs. chronic traumatic histories. Classification issues such as these will continue through field trials for the DSM-V (Magritte, 2000).

In 2013, American Psychiatric Association revised the criteria for PTSD, which requires the following criteria: re-experiencing the event, alterations in arousal, avoidance, negative alterations in cognition and mood (APA, 2013). It also requires a clinically significant distress or impairment in social, occupational or other important areas of human functioning. This should last at least one month or longer and the disturbance should not be caused by substance or medical condition.

CONCLUSIONS

As the time progress and the clinical and theoretical experiences grow, new information would accumulate and help us to understand better the phenomenon of traumatic experiences. By itself, PTSD is very complex and heterogeneous set of symptoms that may resemble anxiety or affective disorder. Psychiatrist, psychologist and mental health workers are making bit-by-bit progress to fully understand this phenomenon. Especially, neurological sciences and cognitive sciences are discovering new advances to help us to fully understand

this mysterious experience. This paper should serve for the purpose of these gaps.

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

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