Posttraumatic Stress Disorder and Acute Stress Disorder in DSM-V: changes and challenges

E.S. Molchanova

American University in Central Asia (Bishkek, Kyrgyzstan)
E-mail: emolchanova2009@gmail.com

Copyright ©: E.S. Molchanova

Abstract

Background: Posttraumatic Stress Disorder (PTSD) is very useful for professional purposes. However, it is still one of the most disputable nosological categories in ICD-10 and DSM-IV-TR. A new classification of mental disorders — DSM-5 — was published on May 2013 and introduces a number of changes that are designed to facilitate PTSD and Acute Stress Disorder (ASD) diagnoses. This work is intended for comparison of PTSD and ASD descriptions in the former version and in the superseding American classification of mental disorders, and aimed at the analysis of possible challenges in application of upgraded diagnostic criteria.

Method: For demonstration purposes of the differences between prior and new descriptions of diagnostic categories a simple comparison of DSM-IV-TR and DSM-5 texts is used. The article provides a Russian translation of DSM-5 criteria of PTSD and ASD. In order to give a practical example of application of updated PTSD criteria a case analysis method is used.

Results: Overall the DSM-5 diagnostic criteria for PTSD almost replicate criteria described in the previous classification system. The major differences include the following: (1) Posttraumatic stress-related disorders are now included in a separate category and were eliminated from the section titled “anxiety disorders”; (2) Two additional subtypes of PTSD were named: PTSD in preschool children, and PTSD with dissociative symptoms. (3) Additional changes were made in the list of diagnostic criteria with the purpose of making the process of PTSD and ASD diagnosis easier, increasing validity of the diagnoses, enhancing symptom detection, and lowering diagnostic threshold. Clinical examples provided in the article still demonstrate unidimensional, western-oriented approach to the diagnosis of posttraumatic stress-related mental disorders. New DSM edition emphasizes behavioral manifestations of disorders, which can distance a psychiatrist from the inner experiences of the patient even more. Cases when a patient’s condition met all the criteria required for PTSD diagnosis are quite rare and are found either among those individuals who acquired western education, or in military personnel.

Conclusion: PTSD still seems a convenient amalgam of mental disorders evoked by extreme trauma. An integrated, multidimensional approach to assessment and treatment of individuals in emergency hardship situations that exceeds the limits of clinical protocols is needed.

Keywords: Posttraumatic Stress Disorder, Acute Stress Disorder, classification of mental disorders, case analysis.

Bibliographic reference


The construct of Posttraumatic Stress Disorder despite all its conveniences still raises strong doubts about appropriateness of its use [10]. During one of the congresses of the World Psychiatric Association a leader of an authoritative division evoked a burst of indignation of the audience, saying that “PTSD is nothing but the convenient amalgam of mental disorders caused by extreme trauma”. The speaker’s statement reflected my opinion as well; hence this stormy emotional reaction of the audience that for the most part consisted of psychiatrists — specialists on psychological trauma, was not quite clear for me.

Posttraumatic Stress Disorder in ICD-10 and DSM-IV contradicts the anosognostic approach [1, 3, 4], embraced by these classifications, since its etiology is defined and even outlined as the major criterion (criterion A in DSM). PTSD scarcely can be called a separate
nosologic unit, and it is easily overdiagnosed when a person’s anamnesis includes endured distress [13]. Moreover, frequent use of this category pathologizes normal human reactions to loss, and, finally, as every ill-defined construct, PTSD is interpreted differently depending on the author and on his/her inclination towards a particular psychological school. Numerous studies [6, 10, 11, 13, 14] outlined recommendations for treatment of PTSD related to dental visits and aversive dental experiences (post-traumatic dental care anxiety), abortion (post-trauematic abortion syndrome), feelings of injustice and embitterment (post-traumatic embitterment disorder) and PTSD resulting from watching media. Therefore, criterion A — the first criterion of PTSD in the previous classification — was found to be invalid, since the same set of symptoms could develop as a result of “objectively” not quite disastrous events, which, however, were experienced individually as catastrophes that disturb normal functioning of both children and adults.

Previously, in DSM-IV, Posttraumatic Stress Disorder was classified as an anxiety disorder, which seemed reasonable from the neurophysiological perspective. Indeed, abnormalities of amygdalae bodies, hippocampus and limbic cortex were detected in patients with PTSD. Furthermore, patients whose PTSD diagnoses were verified, demonstrated formation of a short response to a threatening stimulus that did not affect the cortex [7, 8], which, apropos, is typical of specific phobia. From this point of view a classic case of little Albert who was conditioned to fear white reds may be considered as PTSD in a child younger than 6 years, and moreover, it is possible to detect manifestation of all the necessary criteria of this disorder. Unfortunately, Watson’s experiment (1920) took place 60 years earlier than PTSD category was introduced into psychiatric thesaurus, and the lack of attention to psychological trauma made this cruel case study possible. Apart from a phenomenological likeness of PTSD to other disorders, especially to dissociative and anxiety disorders, there is a whole number of issues related to this diagnostic category. One of them is ethical and social and consists in transformation of PTSD into money-maker — a source of income for numerous organizations. This phenomenon illustrates a philosophical notion of unity and conflict of opposites (Profiting from Tragedy). An example of the Poverty Reduction Strategy Program (PRSP) that allegedly struggled against child poverty immediately strikes my mind: during the period of its active functioning in Bishkek this organization gave state receptions in expensive restaurants spending amounts of money enough for satisfying basic needs of thousands of children.

Despite the skepticism related to this diagnostic category, the “grant rush” based on sufferings, and sales of programs, funds, medications etc., it must be admitted that a clear definition of trauma as the major etiological factor causing a particular disorder, managed to call attention of “the powers that be” to mental health issues, which, in some way exist in any, even relatively developed country. The universally received opinion about the increase in violence in the modern world (which, as shown by Nazaretyan, does not correspond to the historical facts [2]), transforms emergency psychiatry into one of the most popular and, undoubtedly, opportune branch of mental health sciences. An obvious case is the publication of this handbook, which would be impossible without tragic events of 2010.

In DSM-5 [4] Acute Stress Disorder as well as Posttraumatic Stress Disorder was removed from the group of anxiety disorders to a new section titled “Trauma- and Stressor-Related Disorders”. Apart from that, in addition to the “adult version” of PTSD, separate criteria have been added for children age six years or younger.

Overall, the diagnostic criteria for PTSD stipulated in the DSM-5 almost replicate those formulated in the previous version of the Diagnostic and Statistical Manual of Mental Disorders. The major differences include the following:

1. **Posttraumatic stress-related disorders are now grouped into a separate category and were removed from the “anxiety disorders” section.** Interestingly, it had been done by ICD-10 earlier than in the DSM classification system. It is reasonable to
assume that since the moment of DSM-5 release, interest in PTSD, at the very least, has not decreased. This topic is still urgent enough and attracts attention of both researchers and grantors, who donate funds to help victims of disaster. Most probably PTSD will remain one of the most normative (Normative = regulatory. Maybe socially desirable? Excusable? Conventional? Generally acceptable? I don’t clearly see what you mean) ways to make money for mental health professionals, which is not necessarily beneficial for the aggrieved population itself.

The next observation sums up the interviews conducted with child psychologists of Bishkek, who participated in this project.

Right after the Osh massacre one of the influential international NGO granted money for creation of the summer camp for traumatized children. According to the project of grantors, traumatized children were supposed to “distract their minds from their sorrows and have a good time” at the Issyk-Kul shore. Selection of children who had the luck to go to the summer camp for free was performed by the representatives of the local branch office of this organization. The project was supported and advertised accordingly by the government. It turned out that children, who witnessed massacres, lost their family members and even were held captive, got in one camp with quite problem-free children from prosperous families of all sorts of officials and functionaries. Psychological correction and psychotherapy were conducted by both invited international experts, who needed a local interpreter, and child psychologists from Bishkek.

Rosy progress reports presented by the grantees did not quite reflect reality. Aggrieved children missed their parents and often cried. Moreover, some of them were screaming at nights disturbing other, relatively healthy children. As a result, some previously healthy children started manifesting signs of distress: bad mood, behavioral and sleep disturbances.

Upon arrival from the summer camp aggrieved children endured secondary traumatization finding themselves in a ravaged city, rather than in the ideal camp conditions isolated from reality. Parents of some of the previously healthy children had to consult a child psychiatrist in the Osh Regional Center of Mental Health.

Recommendations for working in conditions under which an immediate evacuation is not necessary state that separation of children from parents after traumatizing events is undesirable. Majority of children sent to the summer camp were not given an indication for an immediate moving to a safer or quieter place. It should be taken into consideration that simultaneously with afore-mentioned initiative various local summer camps and playgrounds for children were organized. Therefore, children could engage in creative work and receive psychological treatment without being detached from their homes and families. Parents were enabled to do their businesses, restore their household destroyed by mass disturbances and take care of legal issues.

Mentally healthy children who “were having a good time” at the Issyk-Kul shore became tertiary traumatized, and, subsequently, sought for professional help.

2. Two additional subtypes of PTSD were named: PTSD in children and PTSD subtype with dissociative symptoms.

3. Three major PTSD symptom clusters are now four in DSM-5. Traditional criterion C (avoidance symptoms) is now divided into a cluster of numbing symptoms (Criterion C) and a cluster of behavioral avoidance symptoms (Criterion D). It is specified that this differentiation is made basing on the results of factor analytic research, and PTSD diagnosis must include at least one of the avoidance symptoms [15].
4. Former criterion A2 (subjective reaction) has been eliminated from the list of symptoms that previously comprised criterion A. The fact that criterion A does not add to the accuracy of the diagnosis serves as the substantiation of the change.

5. Three new symptoms have been added:
   a. Two in criterion D (negative alterations in cognitions and mood associated with the traumatic event) that are formulated as follows “persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others” and “persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).”
   b. And one in criterion E “Irritable behavior and angry outbursts (with little or no provocation)”.

It is presumed that afore-listed changes that were introduced in the list of diagnostic criteria will lead to more accurate diagnosis. It should be noted, that in the new edition of DSM (and this is true of all disorders, not PTSD only) the emphasis is put on behavioral manifestations of disorders, which, in my opinion, can distance a psychiatrist from the inner experiences of the patient even more.

Translation of the diagnostic criteria for Acute Stress Disorder, stipulated in new edition of DSM [4] is given in the Russian version of the article.

The diagnostic criteria for Acute Stress Disorder replicate PTSD symptoms described in DSM-5. It should be noted that DSM-5 still does not single out Acute Stress Reaction category (F43.0 in ICD-10), “which usually appear within minutes of the impact of the stressful stimulus or event, and disappear within 2—3 days (often within hours) [1]. Probably in new ICD-11 normal reactions on abnormal situations will be eliminated from the diagnostic system, and will be available in the ASD description only — a category that has not been incorporated into ICD yet.

DSM-5 description of PTSD is still unidimensional, and does not embody cultural dimension. As a matter of fact, PTSD category may be considered a product of western culture and representation of a western model of suffering. As it was proven by Hans Selye, neurophysiological response to intensive stress is universal, but behavioral fringe of biological reactions, its interpretation, relationship to traditions and beliefs, use of coping-strategies as well as the manners of responses typical of each particular culture cannot be identical. For instance, a behavioral reaction of an inhabitant of the Kyrgyz Republic may drastically differ from a response of a resident of the United States of America.

One of our colleagues — a social psychologist and anthropologist, who used to work in American University of Central Asia — participated in the development of the interdisciplinary online course for students from two countries: the Kyrgyz Republic and Afghanistan. During one of the first video sessions he declared that “most people of Afghanistan suffer from Posttraumatic Stress Disorder, and PTSD in this country can be considered as a result of cultural influence, cruel and destructive by nature”. This thoughtless statement, to say the least of it, gave rise to a boisterous discussion among Afghan students, who demanded to list the diagnostic criteria of PTSD. As would be expected, nobody of the students present during the class recognized PTSD symptoms in themselves. One of the Afghan students summarized this heated dispute saying “We were born and we live under conditions that cannot be called safe. Some of us will move to some western countries in search of a fortune. At this moment we are not aware that life can be different. We are used to things that would seem overwhelming and stressful for a citizen of the USA, but we continue to live, love, make families and take care of our parents. Our life is unsafe, but customary. Perhaps, our esteemed professor rather should have tried to diagnose himself with PTSD.”
Western diagnostic and interventional templates, instilled into third-world countries (and, incidentally, the Kyrgyz Republic is rated as one of them) by international experts with neocolonial persistence, at times lead to ridiculous situations that would even deserve mockery if they would take place in less tragic context. Thus, a social worker who visited Osh in October 2010 was extremely surprised by the fact that local specialists refused to apply a model of psychosocial intervention developed by her colleagues for victims in one of the African countries. From her perspective, rejecting such offer local mental health professionals displayed terrible ingratitude.

Observation

A representative of an authoritative international NGO, who holds a position of psychologists in this organization, diagnosed all adolescents she consulted in Jalal-Abad with “suicidal tendencies”. She was guided by their nonverbal behavior — none of the teenagers was maintaining eye contact during the sessions. Accordingly, her report on the work done reflected an extremely high level of traumatization among Jalal-Abad populace. Indeed, the level of traumatization was high, but it was impossible to diagnose suicidal tendencies solely on the grounds of the absence of eye contact. The point is that it is considered inappropriate in Kyrgyz culture to look older people in the eyes, and adolescents who involuntarily became clients of this psychologist were much younger than her.

Our work with massacre victims in Osh and Jalal-Abad regions allowed us to identify a few peculiarities of acute and chronic disorders related to the impact of stressors:

- As a primary reaction on stress in Kyrgyz people: fight reaction were prevalent among men, while movement storm predominated among women. Numbing occurred fairly rarely (examples are provided in one of the previous chapters of the handbook). All types of reactions (fight-flight-numbing) were found among Uzbek men, while among Uzbek women fight responses and numbing were prevalent.

- Signs of distress were often somatized, which was perceived as exacerbation of chronic illnesses observed formerly. Hence, an option of consulting a mental health professional was not even considered.

- In cases when a victim linked his/her worsening of somatic condition to endured distress, the blame was ascribed to representatives of the other ethnos (“it is all Uzbeks’ fault, or it is all because of Kyrgyz people”).

- Folk healers and/or religious figures (moldos) still remain the major source of help. Surprisingly enough, their services turn out to be more helpful than those of social workers and psychologists from the far abroad.

Observation

One of our young colleagues — a Kyrgyz woman that lives in Osh city, who witnessed many deaths of her neighbors, and has a good command of Russian — once shared her experiences during the break of one of the numerous trainings:

"I know I need help, but I don’t know how to communicate with all these alien psychologists. One American told me that I’m ill because of the distress that I’ve endured. I know I am not ill; I am just feeling unwell and have a heavy heart. He keeps making inquiries about my feelings during the massacre, but I feel uncomfortable telling others about my experiences. He offered me pills, but I don’t want to take them. I went to bubu ("knowledgeable", "a healer") on Saturday who calmed me down and reminded me of those who need me, and whom I ignored — my husband and children. She also told me that I should make a sacrifice and help others — my neighbors, who are having a harder time. Almost every family lost close people, but my family managed to survive this nightmare.”

The folk healer who belonged to the same culture as the object of our case study turned out to be more understanding, empathetic, and, as a result, more helpful than a
representative of the Western culture. A psychologist, who was taught western morels of intervention, had quite a vague idea about culturally-determined behavioral models of Asian women.

- Cases when a patient’s condition met all ICD-10 criteria for PTSD were quite rare and were found either among those individuals who acquired western education, or in military personnel. Among civilians dissociative symptoms and signs of somatization were prevalent.

**Observation**

*Business trip of M.P., a 34 years old man working as epidemiologist, took place in the beginning of June and concurred with Osh massacres. The patient witnessed homicides and arsons. He made an attempt to escape from the city with other victims, but the group was detained by armed people wearing black masks. Gunmen threw gas on someone from the group and burned this person alive. M.P. rushed to help, trying to put out fire, but was stopped by one of the gunmen, who threatened him saying that he will suffer the same fate. People that formerly tried to escape were in captivity for five hours. Fortunately, nobody else suffered, at least, physically. M.P. managed to return back home two days later. He had some rest and felt relaxed while being at home, in safe and calm environment. However, 3 months later he started having recurrent distressing dreams the content of which reflected the nature of the trauma: he dreamed that gunmen throw gas on him and set him on fire. He began avoiding places that smelled of gasoline, did not drive car anymore, and experienced constant tension and fear for his life. He independently diagnosed himself with PTSD basing his judgments on different web-sources and turned to a professional for help.*

Epidemiologist is a Kyrgyz National Medical Academy graduate and was familiar with the medical models of mental disorders. Therefore, he sought for professional help, rather than for folk healers’ services.

**Observation**

*That night when military conflict in Osh city has begun, Almaz was at home with his family — his mother, wife, and three children. Almaz remembered nothing about the events of that night: neither could he recollect how he got to the National Hospital in Bishkek after covering 720 km., nor he knew what happened to his family. Later it was found out that he simply went to the garage, got to his car and drove away in unknown direction, leaving his alarmed family at home. Only three days later his family was informed that he is in Bishkek. A few days after a happy reunion, Almaz started complaining of cardiodynia and arrhythmia. Neither multiple cardiac examinations, nor medical examinations performed by neurologists and other physicians detected somatic pathologies. Almaz turned for psychotherapeutic help a month after he visited both a folk healer and a Muslim priest — moldo, who assured him that he is cleansed now.*

This observation illustrates a course of Acute Stress Disorder with dissociative symptoms and somatization, typical for the population of the Kyrgyz Republic, but such category simply does not exist in ICD-10. Diagnosis of acute stress reaction in this case was valid during the first two-three days after a traumatic situation. Despite the fact that Almaz’s condition did not meet all required criteria, a patient was diagnosed with PTSD.

It seems that prior to the introduction of PTSD category in psychiatric nosology (in the Kyrgyz Republic is has been done in 1990), Almaz could be diagnosed as a person experiencing hysterical neurosis with hypochondriac symptoms, while M.P.’s case — would be considered as a person with anxious-phobic neurosis.
The conceptual world and the material world are interrelated. Determination of existence of any mental disorder by means of introduction of a particular diagnostic category inevitably leads to its usage even in those cases, when it is unnecessary. In our opinion we also should not lose sight of legal nuances of PTSD diagnosis — this label turns a person into a victim and involuntarily increases probability that individual will derive secondary gain from disorder.

A strange genius, Socrates, was convinced that the emergence of writing is detrimental to independent thinking. “They will be hearers of many things and will have learned nothing; they will appear to be omniscient and will generally know nothing; they will be tiresome company, having the show of wisdom without the reality” [3, p 276]. He considered that the spread of the written word ensured supremacy of unidimensional (linear) thinking and religions based on dominant, static ideas that appeal to blind belief and submission to power.

We are by no means trying to belittle social, legal and professional importance of PTSD diagnostic category. However, we stand up for more complex and multidimensional approach to assessment, diagnosis and emergency intervention, which, if necessary, should exceed the limits of clinical protocols and diagnostic recommendations of psychiatric Bibles.

References

