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Commentary: The Evolving Conception of Posttraumatic Stress Disorder - reflections on  
Danzi and La Greca (2016)

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In formulating posttraumatic stress disorder (PTSD) for the first time in 1980, the American Psychiatric Association's DSM-III committee was obliged to rely on evidence and theory concerning responses to a variety of serious but not necessarily traumatic stressors. They also had available detailed case material, largely from people exposed to trauma over long periods (war veterans, victims of domestic violence). Accordingly, the picture of PTSD that emerged emphasised the impact of extreme, usually chronic stressors. It consisted of twelve symptom criteria, organised into re-experiencing, numbing of responsiveness to the external world, and a miscellaneous group of cognitive or autonomic symptoms. PTSD in DSM-III differed from earlier stress-related diagnoses in being a potentially chronic condition and not requiring that the person be free of prior or concurrent psychopathology. By the time of DSM-III-R in 1987, PTSD was becoming a more common diagnosis applied to less extreme stressors than had originally been envisaged, including single experienced incidents, witnessed events, and severe events happening to close others, particularly relatives. The number of symptom criteria increased to seventeen. The numbing symptoms of DSM-III were expanded to include psychogenic amnesia and a greater emphasis on deliberate avoidance, and the miscellaneous symptoms divided between the existing two symptom clusters and a third cluster reflecting high arousal.

In 1994 DSM-IV introduced objective and subjective stressor criteria, whereby the diagnosis required not just a specific type of traumatic event but a reaction involving fear, helplessness or horror. Significant distress or functional impairment was also required. DSM-5 in 2013 brought further changes, with symptoms reflecting deliberate avoidance and numbing being placed in separate clusters with their own thresholds, and three additional symptoms being added. The requirement for fear, helplessness and horror was removed in favour of a symptom reflecting a greater breadth of negative emotions. Although a number of important improvements were made, PTSD remained the most complex disorder in the DSM

manual, with over 630,000 different combinations of symptoms qualifying for the diagnosis (Galatzer-Levy & Bryant, 2013). As originally formulated in DSM-III, it continued to reflect the varied and symptomatic presentations that are more strongly associated with chronic or repeated trauma than with single-incident trauma. One consequence has been that cases of ‘partial PTSD’ accompanied by functional impairment are often identified in adults and children, suggesting that the threshold might be too high. Under DSM-5 rules, however, significant alterations to the criteria were not able to be introduced without compelling evidence (Friedman, 2013).

It was against this background that the proposals for measuring PTSD in ICD-11 were formulated. As noted by Danzi and La Greca (2016), these involved a radical shift designed to simplify diagnosis and distinguish PTSD from other disorders by focussing on a small set of six core symptoms, two from each of three clusters reflecting re-experiencing of the traumatic event in the present, deliberate avoidance, and a continued sense of threat. The rationale for the choice of symptoms has been explained elsewhere (Brewin, 2013; Brewin, Lanius, Novac, Schnyder, & Galea, 2009). Fear and horror resumed their central place in PTSD, although it was recognised that they were not always the most prominent emotions. In contrast to ICD-10, functional impairment was now required. Preliminary structural analyses suggest that the three symptom clusters fit the data well. Prevalence estimates indicate that in adult samples rates of ICD-11 PTSD are substantially lower than ICD-10 and broadly comparable to, but often slightly lower, than DSM-based PTSD. The overlap between cases identified using different systems tends to be low, however.

The fact that PTSD in children might present differently was recognised in DSM-III-R, and the accumulation of empirical data has strongly indicated that as a result PTSD is likely being under-diagnosed (Scheeringa, Zeanah, & Cohen, 2011). This has now resulted in

the pre-school subtype introduced in DSM-5. The subtype recognises that the nature of traumatic intrusions may be different in this age group, with the possibility of repetitive play and of an absence of overt distress. Further, the difficulty in identifying avoidance and numbing means that the threshold for these symptoms is greatly reduced. However, the impact of developmental factors on diagnosing PTSD in older children has not received sufficient systematic attention (Scheeringa et al., 2011).

Although ICD-11 has not yet specifically considered whether its proposed PTSD criteria need to be modified for children, it would appear that the absence of numbing symptoms might facilitate the diagnosis. To date two studies have compared ICD-11 with DSM-IV criteria. One recruited a sample of traumatised children and adolescents who had already been selected to receive treatment and were required to show one re-experiencing, avoidance, and hyperarousal symptom (Sachser & Goldbeck, 2016). Although the lower ICD-11 avoidance criterion had the effect of including extra cases, overall the requirement to report specific re-experiencing and hyperarousal symptoms led to a reduction in prevalence from 76% to 61% relative to DSM-IV. There was considerable comorbidity in the sample, and it is possible that those losing a PTSD diagnosis would still have qualified for another diagnosis. Another investigation recruited adolescents and young adults involved in two school shootings (Haravuori, Kiviruusu, Suomalainen, & Marttunen, 2016). In this case use of ICD-11 resulted in a slightly higher prevalence rate than DSM-IV (22% vs. 19%), and reflected more significant exposure to the traumatic incident.

Danzi and La Greca's (2016) findings are therefore important, both in focussing on the 7-11 year old age group and in comparing ICD-11 with DSM-IV and DSM-5. Like Haravuori et al.'s sample, Danzi and La Greca's children had not been preselected for treatment and so were likely to be more representative of those exposed to trauma than those

studied by Sachser and Goldbeck (2016). Again like Haravuori et al., Danzi and La Greca found relatively low levels of symptoms reflecting problems with cognition and mood, prevalence rates that were broadly similar across diagnostic systems, and relatively low levels of agreement between cases identified using different systems. Despite this all systems were associated with risk factors established in the literature. What is potentially important is that in both studies ICD-11 uniquely identified more children than the DSM-based classifications.

The findings reported by Danzi and La Greca (2016) have a number of significant implications. As they note, it may well be that the preschool subtype of PTSD identified in DSM-5 needs to be employed with older children as well. The disagreement between identified cases, characteristic of the adult as well as the child literature, is also concerning, but prompts us to look more critically at how we diagnose PTSD and whether DSM-5 and ICD-11 have accurately described the disorder. Although Danzi and La Greca's results may indicate that ICD-11 has greater sensitivity for this age group, they found some cases identified by DSM-based systems that were not identified by ICD-11. It is important not to assume that one of the diagnostic systems is necessarily better than the other but to use the discrepancies to refine both systems and to clarify the boundaries with frequently comorbid conditions such as depression. The way PTSD is conceptualised has been evolving since 1980 and ICD-11 has raised a number of new and important questions. What we do know is that PTSD is often a chronic condition among children associated with lasting disadvantage (Scheeringa et al., 2011). It is therefore a matter of great urgency to address these diagnostic questions and ensure children who need our help are not overlooked.

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