The Cutting Edge

CAN WE FIX PTSD IN DSM-V?

Richard J. McNally, Ph.D. is Professor and Director of Clinical Training in the Department of Psychology at Harvard University. He is the author of 320 publications, including the books *Panic Disorder: A Critical Analysis* (Guilford, 1994) and *Remembering Trauma* (Belknap Press/Harvard University Press, 2003). A major focus of his research concerns cognitive abnormalities associated with anxiety disorders, especially panic disorder, obsessive–compulsive disorder, and posttraumatic stress disorder. He is a fellow of the American Psychological Society, winner of the 2005 Distinguished Scientist Award from the Society for the Science of Clinical Psychology, and on the Institute for Scientific Information's "Highly Cited" list for psychology and psychiatry [top 0.5% of published authors worldwide in terms of citation impact].

The American Psychiatric Association (APA) has launched the process that will culminate in the publication of the fifth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-V) in 2012. As part of this process, chairs of diagnostic workgroups have been surveying clinical researchers from around the world, soliciting advice about how to solve pressing nosological controversies. In this article, I expand on suggestions that I provided as an advisor to the committee responsible for posttraumatic stress disorder (PTSD).

CONCEPTUAL BRACKET CREEP IN THE DEFINITION OF TRAUMA

In contrast to most DSM-III syndromes,[1] PTSD had an etiological factor as one of its defining criteria: exposure to a traumatic stressor. The authors of the DSM-III assumed that a circumscribed set of stressors uniquely possessed the capacity to produce the symptomatic profile of PTSD. These events fell outside the boundary of ordinary human experience and produced distress in almost anyone. Canonical exemplars included rape, natural disaster, combat, and confinement to a concentration camp. Stressors falling within the perimeter of everyday life, such as divorce, job loss, or developing a chronic illness, presumably lacked the capacity to cause PTSD.

However, some people develop PTSD-like symptoms after exposure to subtraumatic stressors.[2] Concerns about denying these sufferers the diagnosis, and hence reimbursable treatment, motivated the expansion of the concept of trauma in subsequent editions of the DSM.

The concept of traumatic stressor embodied in Criterion A in DSM-IV-TR[3] has two parts. Criterion A1 broadens the concept of a stressor, embracing direct exposure, vicarious exposure, and indirect, informational exposure. Criterion A2 specifies that the person must have experienced helplessness, extreme fear, or horror as the event was unfolding. Only if a person meets both parts of Criterion A does he or she qualify as a trauma survivor.

Hence, the DSM-IV-TR concept of trauma brackets three kinds of people as trauma survivors. One group consists of direct recipients of serious threat or harm, such as combat veterans or rape victims. A second group includes personal witnesses of trauma experienced by others, such as bystanders present at a drive-by shooting. The third group, new in DSM-IV, includes people who are "confronted with" information about threats to others, such as horrified viewers of television coverage of the September 11, 2001 terrorist attacks.[4]

According to Schlenger et al.'s[5] survey, about 4% of Americans living far from the traumatic events developed probable PTSD, apparently by watching television coverage of the attacks in the comfort of their living rooms. These viewers now qualify as trauma survivors just as much as do people who escaped the World Trade Center. The possibility that television could suddenly trigger the illness in millions of Americans probably never crossed the minds of the nosologists who formulated the concept of PTSD in DSM-III.[6] Yet as Young[7] wryly observed, we now have something he calls "PTSD of the virtual kind" (p 21).

Thanks to this conceptual bracket creep in the definition of trauma[8] (pp 279–280), nearly everyone in America counts as a trauma survivor today, at least according to some surveys. For example, a major

*Correspondence to: Richard J. McNally, Department of Psychology, Harvard University, 33 Kirkland Street, Cambridge, MA 02138. E-mail: rjm@wjh.harvard.edu

Photo credit: Harvard News Office Staff Photographer/Justin Ide

DOI 10.1002/da.20586
Published online in Wiley InterScience (www.interscience.wiley.com).

Newsweek

'A Pill for Every Ill'

By John Ericson / February 6, 2014 2:48 PM EST

If there were fewer possible psychiatric diagnoses, would fewer people consider themselves ill? A growing number of health experts suspect that psychiatric care is drifting toward "diagnostic inflation," in which the rate of mental disorders balloons as a result of new diagnoses - and not due to an increasingly troubled population. What's worse is that this process may be fueled by the very document that is supposed to control it.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a 1,000-page behemoth that is now in its fifth edition, gives researchers and clinicians across the country a common language for discussing the ins and outs of a mind that is not well, ideally allowing everyone to agree on who is and isn't ill. The manual is produced by the American Psychiatric Association (APA).

Although the APA has insisted that its signature document should not be read as a rulebook, with definitions set in stone, a publication of this scope and caliber inevitably shapes the field. If the DSM-5 says your pain doesn't align with its definition of pain, you can be certain that, in the eyes of most psychiatrists, lawyers and policy makers, you're not in pain.

Now consider the opposite: What if the DSM-5's definition of pain illuminates a problem you didn't know you had - a pain you didn't know was even considered a real issue?

When the APA released the fifth edition of its manual in May 2013, it was instantly criticized by several researchers and clinicians, who claimed that some of the revisions and modifications reflected the agenda of an editorial panel that did not have the public's best interest in mind. For example, many therapists and parents denounced the decision to define Asperger's syndrome as a part of the autism spectrum rather than a stand-alone diagnosis. Some said it would skew statistics. Others said it would mess with identities.

"I personally continue to believe that Asperger's stands alone from autism," Andy Novis, a 50-year-old artist, handyman and personal trainer who received his Asperger's diagnosis shortly before the publication of the DSM-5, wrote in an email to *Newsweek*. Save for a few social anxieties, Novis navigates the world with ease, communicates about his experiences with aplomb, and prides himself on independence as he awaits the right time to start a family of his own. "While I accept that Asperger's may be part of the autism spectrum as a whole.... I personally do not see myself as autistic in any way."

That, however, wasn't the biggest concern. Other experts, including Sheldon Krimsky, professor of Urban & Environmental Policy & Planning at Tufts University, have pointed out that changes to the DSM can also be big business, with lots of downstream profit for everyone involved. If, for example, the DSM-5 finds a new "indication" for a particular drug, the developer can renew its patent and keep generic competitors off the market for another three years. For most industries, this would have a pretty modest impact on revenue. But in the business of curing ills, in which price tags can be very high and demand is often buoyed by nature, those three years can make a huge difference.

Take, for example, the drug Cymbalta - one of a group of drugs referred to by the industry as "blockbusters" - drugs that rake in at least $1 billion in annual revenue. Cymbalta, which is prescribed for major depressive disorder and generalized anxiety disorder, earned its blockbuster title almost five times over in 2012, bringing in nearly $5 billion to developer Eli Lilly. Lilly's patent on Cymbalta expired in December 2013, and the developer should soon begin to lose revenue to generics.

But thanks to the changes made by the APA to the DSM, the money will likely keep rolling in.

In past editions of the DSM, a so-called bereavement exclusion from major depressive disorder recommended that actively grieving individuals not be diagnosed with depression. In the DSM-5, this recommendation has been erased, giving rise to "bereavement-related depression" - a subset of major depressive disorder that is treatable by all the standard methods (and drugs) that ease depression. But if you didn't need to treat the loss of a loved one with medication in 2000, is it really necessary in 2014?

Companies like Lilly certainly want it to be - and they may just get their way. Public records regarding clinical investigations show that Lilly's expired patent on Cymbalta will in all likelihood be renewed, as it is currently the focus of a new trial for the pharmacological treatment of bereavement-related depression. In other words, it's going to end up being the drug of choice for treating what was merely called "grief" at the time of Lilly's original patent filing.