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EDITORIAL

PTSD: Constructs, Diagnoses, Disorders, Syndromes, Symptoms, and Structure

Daniel S. Weiss
Department of Psychiatry, University of California, San Francisco, San Francisco, CA USA

The fifth revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) regarding posttraumatic stress disorder (PTSD) has been accompanied by debates applicable to the nomenclature at large as well as those issues specific to reactions to exposure to traumatic stressors. Among the former, a core dispute involves dimensional versus categorical approaches (e.g., Linscott & van Os, 2010). Among the latter are (a) where PTSD and acute stress disorder (ASD) belong in the nomenclature (i.e., remain or not among disorders currently conceptualized as anxiety disorders); (b) should complex PTSD (CPTSD) be added to the list; (c) what changes, if any, should occur in the criteria; (d) what way should they be modified for children, and (e) what is the evidence and conceptual rationale for these modifications. A parallel process is occurring in the 11th revision of the *International Classification of Diseases* (*ICD-11*), making the discussion and decisions likely to have scientific and pragmatic worldwide implications. With respect to PTSD, as of this writing, an outcome for a number of these issues for *DSM-5* have been proposed (see Friedman et al., 2011), the most far reaching of which is a byproduct of an overall revision of the organizational structure of the chapters and listings in the *DSM-5*: the creation of trauma- and stressor-related disorders.

The administrative need for a nomenclature of disorders, diseases, injuries, and treatments is obvious, and the goal of making it easier to use and more reflective of current knowledge is also laudable. Nevertheless, there are conceptual conundrums that the current revisions face and the terms that are used in the manuals have implications regarding the fundamental issues about categories versus dimensions and disorders versus diagnoses. The *DSM* revision has provided an opportunity to reflect on what is at the core of nomenclature, the conceptualization of what are being tabulated, and the nature of the evidence used to inform these decisions.

In his provocative and wide-ranging discussion of mental disorders, Hyman (2010) raised concerns about the reification of mental disorders that followed the introduction of the *DSM-II* (American Psychiatric Association, 1980), but it is clear according to Hyman that the generic *DSM* is a nomenclature of disorders, aimed at "yield[ing] valid disease definitions" (p. 155). The burgeoning influence of knowledge from neurobiology, genetics, and neuroimaging has made understanding the disorders and whether they are or will become diseases much more complicated, but important to address. In an equally provocative discussion, Kraemer (2007) argued that the generic *DSM* concerns "'diagnoses' not 'disorders'" (p. S1) and advocates "the addition of a dimensional adjunct" (p. S10) for every diagnosis to help with the practical aspects of interrater reliability of diagnostic status (Kraemer, Kupfer, Clarke, Narrow, & Regier, 2012) and sophisticated analysis of treatment effects. This suggestion is neutral as to the underlying conceptual status of the listed disorders.

One core issue in the debate about PTSD is its symptomatic presentation, linked questions about its structure, and the special characteristics of exposure to traumatic stressors. The discussion about CPTSD in Resick et al. (2012) suggests that the analysis of CPTSD as a candidate for inclusion in the *DSM-5* (and by extension the *ICD-11*) is best examined using the notion of construct validity (Cronbach & Meehl, 1955). This is a debatable proposition because this implies that PTSD is a construct, like intelligence, not a diagnostic entity, disorder, or disease. Indeed, Meehl himself (1995) did not take the view that the classification problem was one of construct validity. Instead, Meehl advocated distinguishing between evidentiary and definitory criteria, and drew upon the examples of diseases in clinical medicine, where constructs are not a part of the discussion: "The . . . medical model does not identify

Correspondence concerning this article should be sent to Daniel S. Weiss, UCSF Box 0984-F, Department of Psychiatry, 401 Parnassus Avenue, San Francisco, CA 94143. E-mail: daniel.weiss@ucsf.edu

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disease taxa with the operationally defined syndrome; the syndrome is taken as evidentiary, not as definitory" (p. 267). A disease entity in medicine outside of psychiatry is a circumstance of pathology and etiology, and, as Meehl points out, is why one can be asymptomatic, but still have a disease—Magic Johnson and AIDS being one well-known example.

Meehl's conceptualization led to the development of taxometrics (Waller & Meehl, 1998), one of several approaches (Meehl, 2004) aimed at determining whether category or dimension fits the pathological phenomenon. Hyman's worry about reification of diagnoses is just an example of the tendency to introduce simplicity or shorthand labels (e.g., hypertension) even where everyone knows there is no category. It is more pernicious, however, in thinking about psychiatric or mental disorders and is the same cognitive habit of using cutpoints to analyze dimensional data. Medical charts contain periodic recording of systolic/diastolic values, not presence or absence of hypertension.

Why is this discussion germane for the revisions of PTSD in the *DSM* and *ICD*? The answer is that the field needs to be clear to not confuse patterns of symptoms with syndromes or disorders, and further distinguish these from disease entities. AIDS has no biological marker other than the etiology. In the end, there not be any disease entities in psychiatry that map onto the manifestations. There may not be definitory criteria, that mimic the evidentiary, and the manifestation of affective instability in CPTSD may be such an example. A reliably and replicated identified set of signs and symptoms that can be differentiated from another set that overlaps, but does not contain a key aspect of those phenomena (see Figure 1 in Resick et al., 2012), may be different in kind, as has been argued for CPTSD, even if the definitory aspects are many decades away from being identified by genetic or imaging analyses.

The literature in PTSD about the phenomenology has, in my view, suffered greatly by the popularity of latent models and easily available software to conduct confirmatory factor analyses and the concomitant confining exploration of the covariance structure of symptoms to measures that contain only the *DSM-IV* symptoms themselves, such as the versions of the PCL (Weathers, Litz, Herman, Huska, & Keane, 1993). Any serious attempt to look for subtypes of PTSD, or to understand the full spectrum of symptoms triggered by exposure to a traumatic stressor requires casting a much larger net than the 17 symptoms. Such studies do not look at the structure of PTSD, they look at the structure of the measures of the codified diagnostic criteria. Indeed, I would argue that the idea that there is a structure to PTSD misunderstands that manifest symptoms are probabilistic and a rare symptom not measured redundantly will not survive such analyses, but can nonetheless be among the most pathognomic indicators. Discussions of the criteria for most other disorders in the *DSM-5* do not focus on the results of confirmatory factor analyses. Rare, but important symptoms cannot survive such analyses; nevertheless, they may be fully evidentiary in Meehl's sense. Hopefully, committee deliberations will recognize that the essential core of a disorder or disease must allow not only for atypical manifestations and rare symptoms, but also will recognize that when a nonrare manifestation appears to accompany a limited set of exposures, there may indeed be a difference in kind.

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