Diagnosing Trauma-related Disorders with the DSM-5

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Clinicians who provide trauma-focused treatments may be interested to know that there are some significant changes in the recently published 5th edition of the *Diagnostics and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). The changes range from category, to symptoms, to age differentiation. Some of the changes have been welcomed by therapists, others have not. In this article, I will describe the differences in trauma related diagnoses between the two most recent editions of the manual. Also, I will note the benefits and potential ramifications.

At the broadest level of change, a new category of *Trauma and Related Stressors* has been developed in the 5th edition. In the 4th edition, trauma-related diagnoses were listed in sections not specifically noted as being trauma related. For example, *post-traumatic stress disorder* was previously listed in the anxiety section. Other trauma-related diagnoses were also listed in the anxiety section including *acute stress disorder*. As well, trauma-related diagnoses were included in categories unrelated to anxiety. For example, *reactive attachment disorder,* a diagnosis typically conceptualized as a reaction to harmful parenting was listed in the disorders usually first diagnosed in infancy, childhood, and adolescence section. *Adjustment disorders* were included in their own section titled *Adjustment Disorders.*

With the 5th edition, all of the trauma-related diagnoses have been culled from their former sections and placed in a section titled *Trauma and Stressor Related Disorders*. As a whole, the grouping of these diagnoses makes sense as long as clinicians conceptualize these diagnoses as being the result of traumatic events. This causal relationship is notable for a very significant reason. The first and second editions of the DSM were based on Freud's theory of psychoanalysis. The disorders listed in those editions were considered *reactions*. The American Psychiatric Association made significant attempts to remove any causal nature from diagnoses in the third and fourth editions. Those manuals were stated to be atheoretical, meaning that there were no causes for diagnoses based upon theory. The newest edition of the manual seems to eschew this trend by providing a section of diagnoses listed as trauma related. At least in this section, the authors are returning to theorizing how diagnoses are developed.

In terms of specific disorders listed in the Trauma and Stressor Related Disorders section, there have been individual changes in the criteria for each diagnosis. Clinicians diagnosing *posttraumatic stress disorder* will notice a few of them. Criterion A now requires that clinicians note specifically whether or not the traumatic event was witnessed or experienced. Also, the former criterion A2 (previously noting that the person's response included fear, helplessness, and horror) has been eliminated from the manual. This is a significant change. The former criterion A2 was a requirement in the fourth edition. Those persons who experienced numbness or did not report fear, helplessness, or horror would have been excluded in the past from a PTSD diagnosis.

Additionally, there were three major symptom clusters in the fourth edition. In the fifth edition, there are four symptom clusters. Negative emotional states had been added. This is a needed change. Clients who report PTSD often experience depression or other negative emotional states in conjunction with or as a result of life changes due to PTSD. Finally, the authors have developed clearly distinguishable symptoms for children and adults. Similarly, the changes to the *acute stress disorder* diagnosis are similar to posttraumatic stress disorder. Also, clients need to only meet any 9 out of 14 symptoms related to intrusion, negative mood, disassociation, avoidance, and arousal to meet the acute stress disorder diagnosis.

Adjustment disorders have been included in the trauma and related stressors section. In the newest edition, they are considered a response to stress. In the fourth edition, they were conceptualized as a category for people who did not meet the criteria for a more significant disorder. Remember that the authors of the fourth edition defined *significance* as causing distress and impairment. This is another significant change. Adjustment disorders were considered by some to be of lesser significance than most other diagnoses because they were considered transient with less mental health consequences. The current manual description elevates the significance of the diagnosis to a comparable level with that of other diagnoses. The authors retained the subtypes of depressed mood, anxious symptoms, and disturbance of conduct.

Reactive attachment disorder has also been included in this section. The diagnosis has undergone some drastic changes. In the fourth edition, there were two subtypes of reactive attachment disorder: emotionally withdrawn and indiscriminately social. These two subtypes have been separated into two different disorders. The criteria for both indicate that they are a consequence of harmful or neglectful parenting. Again, the authors are including a theoretical origin for the diagnoses in the criteria. The two diagnoses differ in terms of other criteria and presentation. Reactive attachment disorder can be conceptualized as an inability to form an attachment with an adult. Some children may show no interests in connecting with adults. Other children may display aggression towards adults or caregivers. *Disinhibited social engagement disorder* can be conceptualized as the exact opposite. Children with this diagnosis actively approach unfamiliar adults in a non-hesitant and overly familiar way. These children can be thought of as attaching *too* easily.

Finally, the authors included two catch-all diagnoses in the trauma and related stressors section. *Other specified trauma and stressor related disorder* would be utilized for clients who report a reaction to traumatic events, but the client's symptoms do not fall into any one trauma and stressor related diagnosis. The unspecified trauma and stressor related disorder diagnosis is utilized when the diagnosing clinicians believes there is a trauma related diagnosis, but does not have sufficient information to justify it.

As you have read, the changes have been significant. Clinicians like yourselves and the clients that you treat will ultimately decide if they are appropriate.

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