

Reformulating PTSD for *DSM-V*: Life After Criterion A

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The diagnosis of posttraumatic stress disorder has been criticized on numerous grounds, but principally for three reasons (a) the alleged pathologizing of normal events, (b) the inadequacy of Criterion A, and (c) symptom overlap with other disorders. The authors review these problems along with arguments why the diagnosis is nevertheless worth retaining in an amended form. A proposal for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is put forward that involves abolishing Criterion A, narrowing the B criteria to focus on the core phenomena of flashbacks and nightmares, and narrowing the C and D criteria to reduce overlap with other disorders. The potential advantages and disadvantages of this formulation are discussed.

Despite an enormous increase in knowledge about psychological trauma over the last 30 years, the diagnosis of posttraumatic stress disorder (PTSD) continues to attract controversy. An extreme view, for example, is that it is a “faddish postulate” that has “moved the mental health field away from, not toward, understanding the psychological responses to trauma” (McHugh & Treisman, 2007, p. 221). In this review we evaluate some of the criticisms of PTSD and conclude that it is nevertheless a valuable diagnosis that is worth retaining. Finally, we outline the possible advantages of abolishing PTSD Criterion A while simultaneously making the B–D criteria more explicit and more stringent.

Posttraumatic stress disorder was introduced in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III*; American Psychiatric Association [APA], 1980) as a “monocausal” mental disorder requiring a recognizable stressor “that would evoke significant symptoms of distress in almost everyone” and that was “generally outside the range of usual human experience.” The stressor criterion (Criterion A) was subsequently elaborated in *DSM-III-R* (APA, 1987) to give examples of qualifying events (e.g., serious threat to life or physical integrity). A major justification for PTSD was the previous assumption that stressful

events could only produce transitory mental disturbance, meaning that there was no diagnosis available for individuals who developed long-lasting psychopathology in response to extreme stress.

This idea of a disorder that could be explained entirely by an environmental event rather than by the characteristics of a person, or their interaction, was in marked contrast to other disorders in the *DSM* and was immediately controversial. It soon became clear, however, that traumatic events were much more prevalent than had been assumed, and that typically only a minority of individuals developed PTSD afterwards, facts that fundamentally challenged the conceptual basis of the disorder (Yehuda & McFarlane, 1995). After almost three decades of research we know that although the nature of the stressor and its intensity is important, PTSD has a multifactorial etiology (Brewin, Andrews, & Valentine, 2000).

EVALUATION OF THREE CRITICISMS OF PTSD

Criticism 1: PTSD Pathologizes Normal Distress

One repeated criticism of PTSD has been that it creates a medical condition out of normal distress (McHugh & Treisman, 2007;

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Summerfield, 2001). This is a complex claim and can be taken in at least three different ways. One is that reactions to extreme stress are time-limited, and that PTSD symptoms will resolve naturally of their own accord with no lasting harm to the person. Another possible meaning of the claim is that the “symptoms” of PTSD are ubiquitous reactions to stressful events found in people suffering from normal distress. A final meaning is that PTSD is not biologically distinguishable from normal distress.

The claim that reactions to extreme stress are time-limited, and that PTSD symptoms will resolve naturally of their own accord with no lasting harm to the person was the received view prior to *DSM-III*. Epidemiological studies refute these assertions, and show that extreme stress sometimes leads to severe and long-lasting psychopathology (e.g., Norris & Slone, 2007), as well as to a variety of serious medical conditions (Schnurr & Green, 2004). A follow-up of children who were aged 4 to 11 when they survived the Aberfan disaster in 1966 showed that one third still suffered from PTSD 33 years later (Morgan, Scourfield, Williams, Jasper, & Lewis, 2003). Studies of terrorist attacks similarly distinguish between largely short-term symptomatic reactions in the population who are not directly involved versus long-term disorder in direct victims (Neria, Nandi, & Galea, 2008; Whalley & Brewin, 2007).

A popular view currently is that PTSD reflects a failure of adaptation, whereby normal reactions to extreme stress do not correct themselves (e.g., Brewin, 2003; Shalev, 2003). Thus, what is pathological about PTSD is defined not by the nature but by the persistence of its symptoms. Critics who claim PTSD is nothing but normal distress should be obliged to state how long symptoms can last or how much impairment can be tolerated before it is unreasonable still to regard them as “normal.” This they have yet to do.

Increasing evidence also supports a distinctive biological profile associated with PTSD. A recent meta-analysis examined functional neuroimaging of emotion processing in several anxiety disorders and identified unique patterns of activation in PTSD compared to social anxiety disorder and specific phobia (Etkin & Wager, 2007). Other studies have found distinct patterns of neural activation in PTSD patients as compared to depressed patients (Whalley, Rugg, Smith, Dolan, & Brewin, 2009), and in PTSD patients with and without comorbid depression (Kemp et al., 2007; Lanius et al., 2007). There is also evidence suggesting distinctive patterns of cortisol negative feedback inhibition in PTSD versus depression (Yehuda, Halligan, Golier, Grossman, & Bierer, 2004).

Criticism 2: Inadequacy of Criterion A

Much of the criticism directed at PTSD has focused on the A criterion. In their review, Weathers and Keane (2007) identified three fundamental issues: How broadly or narrowly should trauma be defined? Can trauma be measured reliably and validly? What is the relationship between trauma and PTSD? In this article we

focus primarily on their first and last questions, reviewing evidence that trauma is not exclusively associated with PTSD, that Criterion A is insufficiently specific (i.e., too broad), and conversely that it is excessively specific (i.e., too narrow).

Other disorders are linked to traumatic (Criterion A) events.

The existence of the stressor criterion implies a unique relationship between trauma and PTSD. In fact, trauma is associated with an increased prevalence of other disorders, most commonly depression, generalized anxiety disorder (GAD), panic disorder, and increased substance use (Fullerton & Ursano, 2005). There may also be adjustment disorders, agoraphobia, and specific phobias related to the type of incident (e.g., Handley, Salkovskis, Scragg, & Ehlers, in press; Gabriel et al., 2007). If other disorders can be successfully diagnosed after a traumatic event, the question arises why the same could not be true of PTSD.

Although disorders other than PTSD are linked to Criterion A events, there is considerable evidence that these events do not increase the risk for other disorders independently of the increased risk for PTSD. For example, Breslau, Davis, Peterson, and Schultz (2000) showed that there was an increased risk for depression in respondents who had also developed PTSD, but no increased risk in respondents who were exposed to trauma without developing PTSD. As noted by Breslau et al., similar findings have been obtained for substance use and anxiety disorders, suggesting that PTSD does indeed play a central role in the psychological response to trauma.

Insufficient specificity of Criterion A. The original conceptualization of PTSD as a response to an event “generally outside the range of usual human experience” was broadened when it was realized that the prevalence of traumatic events was higher than had been supposed. In the *DSM-IV* the definition of a traumatic stressor was further broadened in that a person who is not personally and directly exposed to trauma but rather learns about someone else being traumatized now qualifies as having been exposed to trauma. As a result, critics have charged that there is a kind of “conceptual bracket creep” (McNally, 2003) or “criterion creep” (Rosen, 2004) that is causing PTSD to be diagnosed in response to situations that are far removed from the original concept of a trauma.

Among the non-Criterion A events that have been reported to produce PTSD symptoms are marital disruption, affairs, and divorce; collapse of adoption arrangements; employment-related stressors and money problems; bereavement; loss of cattle to foot and mouth disease; frightening Halloween television programs; and breaking up with a best friend (Rosen & Lilienfeld, 2008). A close inspection of the literature, however, shows very few examples of individuals meeting the full diagnostic criteria in these circumstances. Most of the authors cited turn out either to have only expressed their own opinions, or have only collected data on a subset of PTSD symptoms rather than use a proper clinical interview, or are based on samples of children.

Breslau and Kessler (2001) found that the broadening of the stressor criterion in *DSM-IV* did lead to more cases of PTSD, but that most were attributable to learning about the sudden unexpected death of a close relative or friend, an event that could quite reasonably be described as traumatic. Other situations where events not clearly meeting the Criterion A threshold are sometimes associated with full PTSD involve a build-up of stress over a prolonged period. Examples given in the literature include harassment at work, caring for a terminally ill partner, or stalking (Pathe & Mullen, 1997; Scott & Stradling, 1994). Prolonged duration stress leading to PTSD has also been described in military samples (Breslau & Davis, 1987).

Several articles in the aftermath of the September 11, 2001 terrorist attacks documented PTSD symptoms not only among residents of affected areas (e.g., Galea et al., 2002), but among persons living in geographically distant parts of the United States (e.g., Silver et al., 2002). McNally and Breslau (2008) referred to these psychological responses as “virtual PTSD” and suggested that they were “normal, temporary distress responses to a shocking event, not medical symptoms indicative of psychiatric illness.” Marshall, Amsel, and Suh (2008) responded by pointing out that 2 years later persons with acute stress symptoms after 9/11 had almost double the rate of new-onset hypertension and more than triple the rate of new-onset heart problems. Moreover, persons with ongoing terrorism-related worries had more than a 4.5-fold increase in new-onset heart problems (Holman et al., 2008).

Marshall et al. (2008) also emphasized that trauma of lower intensity would in fact be expected to provoke PTSD in vulnerable individuals with a limited capacity to dampen their physiological response to stress. Such vulnerability may be genetic (Hariri et al., 2002), interacting with lifetime exposure to trauma (Stein, Schork, & Gelernter, 2008), or epigenetic (Yehuda, Bell, Bierer, & Schmeidler, 2008). Vulnerability may also be related to greater levels of prior trauma (Williams et al., 2007). Both subjective distress and complexity of symptoms, including comorbidity, may be considered as separate indicators of vulnerability to trauma and stress (Novac & Hubert-Schneider, 1998). Thus, the fact that some events associated with PTSD may appear “insufficient” for Criterion A is only surprising if, as in *DSM-IV*, no allowance is made for variability in enduring stress reactivity.

Excessive specificity of Criterion A. In 1994, *DSM-IV* introduced a two-part stressor criterion for adults (the criteria for children are slightly different). To qualify for a PTSD diagnosis, individuals had not only to have experienced, witnessed, or been confronted with a qualifying event (Criterion A1), but to have responded with intense fear, helplessness, or horror (Criterion A2). This subjective element to the trauma response was introduced despite evidence from the *DSM-IV* Field Trial (Kilpatrick et al., 1998) that there are a wide range of reactions to trauma associated with PTSD, including shame, a sense of violation of trust, emotional numbing, etc. Consistent with their findings, other studies have

identified cases in which trauma exposure is not accompanied by A2 responses although the full PTSD syndrome develops. For example, military personnel are trained to deal with traumatic situations, and report A2 responses less often (Adler, Wright, Bliese, Eckford, & Hoge, 2008; Breslau & Kessler, 2001). Among civilian victims of violent crime a small number had sufficient symptoms for PTSD in the absence of Criterion A2; they reported other intense emotions such as shame or anger instead (Brewin, Andrews, & Rose, 2000). Survivors with traumatic brain injury may also go on to develop PTSD despite losing consciousness and being unable to report A2 responses (Harvey, Kopelman, & Brewin, 2005).

The fact that some individuals develop the complete syndrome without describing intense fear, helplessness, or horror at the time of the trauma is only surprising if, as in *DSM-IV*, it is assumed that the original emotions remain stable over time. Psychological and biological knowledge are, however, more consistent with the idea that memories, and the emotions associated with them, can and do sometimes change (Brewin, 2003; McNally, 2003).

Criticism 3: Symptom Overlap with Other Disorders

The symptom overlap with depression and other anxiety disorders has been frequently noted as a potential problem with the PTSD diagnosis (e.g., Brewin, 2003; McHugh & Treisman, 2007; Spitzer, First, & Wakefield, 2007). Symptom B1 refers to any kind of intrusive memory, image, or thought, a symptom that is common to many psychiatric disorders. Patients who ruminate in the absence of any intrusive memory would therefore currently qualify for Criterion B, even though most clinicians would regard this as more characteristic of depression than PTSD. Emotional and physiological arousal elicited by specific situations, and avoidance of those situations, are part of phobias. Phobic patients would meet Criterion B by virtue of endorsing B4 and B5, without any of the reexperiencing normally associated with PTSD. Social withdrawal, loss of interest, emotional numbing, and hopelessness about the future are all common features of depression. Sleeplessness, irritability, and concentration problems are found in both depression and in generalized anxiety disorder, which can also be accompanied by exaggerated startle. This lack of specificity is of particular concern because there are so many different combinations of symptoms that will all yield a diagnosis of PTSD.

A confirmatory factor analysis by Simms, Watson, and Doebbeling (2002) found that PTSD symptoms fell into reexperiencing, avoidance, dysphoria, and hyperarousal clusters. Although one other 4-factor solution provides a good fit to the data, Simms et al.’s model has received most support to date (Palmieri, Weathers, Difede, & King, 2007). Simms et al. found that the symptoms that overlap most with depression (C4–C7 and D1–D3) did indeed reflect a general dysphoria factor rather than being specific to PTSD. Breslau and Kessler (2001) found that the increase in PTSD rates attributable to the broadening of Criterion A1 in *DSM-IV* occurred mainly because of events consisting of

learning of unexpected injury to or the death of a close friend or loved one. These events are as likely to have induced sadness and grief as fear or horror. It is possible therefore that it is related conditions such as depression, also characterized by intrusive memories and general symptoms of dysphoria, that account for the apparent increase in PTSD rates that has been reported with the broadening of Criterion A1.

Two reexperiencing symptoms that do appear to be distinctive to PTSD are flashbacks and traumatic nightmares. Clinical descriptions of PTSD emphasize the importance of flashbacks, powerful multisensory image-based memories triggered by reminders in which traumatic events are reexperienced in the present rather than in the past (Brewin, 2003; Ehlers, Hackmann, & Michael, 2004). In flashbacks the recall of traumatic images appears to be disconnected from contextual information that normally associates a sensory memory with awareness of a corresponding time and place. They can vary from relatively mild (there is a transient sense of the event reoccurring in the present) to extreme (the person loses all connection with their current autobiographical self and present surroundings while reexperiencing the memory). An emerging literature documents that flashbacks are specific to PTSD rather than mere trauma exposure (Brewin, 2007), that they distinguish PTSD from depression (Reynolds & Brewin, 1998) and that, relative to intrusive memories in depression, intrusive memories in PTSD involve a greater sense of reliving in the present (Birrer et al., 2007). Flashbacks appear to be a particularly sensitive and specific indicator of PTSD (Duke, Allen, Rozee, & Bommarito, 2008), and their characteristic features are predictive of the course of the disorder (Michael, Ehlers, Halligan, & Clark, 2005).

Posttraumatic nightmares are another common distinctive feature of PTSD, occurring in up to 70% of sufferers (Harvey, Jones, & Schmidt, 2003; Lamarche & De Koninck, 2007). Although other anxiety disorders are associated with sleep disturbance, they differ in their specific phenomenological characteristics (e.g., Sheikh, Woodward, & Leskin, 2003). It is of interest that a similar intervention, imagery rehearsal and rescripting, has been used specifically to treat nightmares as well as to treat PTSD symptoms more generally (Lamarche & De Koninck, 2007).

IMPROVING THE DIAGNOSIS OF PTSD

We propose that the way forward for the PTSD diagnosis is to abolish Criterion A and refocus PTSD around a smaller set of core symptoms. First, why abolish Criterion A? Previously in this article we have described the criticisms PTSD has faced for including etiology in its criteria, and the practical difficulties in defining Criterion A in such a way as to include all relevant cases but exclude inappropriate ones. Criterion A has now gone through three iterations, and we regard it as highly unlikely that any formulation for Criterion A will be found that deals with all the problems and inconsistencies that have been identified. Moreover, the evidence we have reviewed on individual differences in sensitization and

vulnerability clearly suggest that specifying triggering events is not just difficult, but undesirable. An individual's symptomatic profile will always be shaped by their genetics, by their environmental history, and by the interaction of the two. To imagine that a single triggering event will always outweigh these runs contrary to contemporary thinking.

Criterion A could be weakened until any event would qualify, as is the case for adjustment disorder. Like some previous authors, however, we think the criterion would be better dispensed with altogether. Solomon and Canino (1990) pointed out that keeping the stressor as part of the diagnosis builds in a confound that makes it impossible to assess empirically to what class of stressor the symptomatic response of PTSD occurs. In the *DSM-IV* Field Trial (Kilpatrick et al., 1998), altering the definition of Criterion A (including allowing low-magnitude events to qualify as triggers for PTSD) had virtually no impact on prevalence rates. In a study of tourists affected by the tsunami of December 26, 2004, the value of Criterion A to predict PTSD Criteria B–D was low so that, based on these findings, the authors regarded Criterion A as dispensable (Kraemer, Wittmann, Jenewein, Maier, & Schnyder, 2009; see also Bedard-Gilligan & Zoellner, 2008). The data we have reviewed in this article are consistent in demonstrating that, with the exception of some cases arising from stress of prolonged duration, the full PTSD syndrome hardly ever occurs in the absence of an event that could reasonably be described as traumatic: In other words, Criterion A simply describes the usual context of PTSD without contributing itself to diagnostic precision.

If Criterion A does not assist in making a diagnosis, and the attempt to define it simply creates controversy, it is hard to argue that it is worth retaining. Like Maier (2006), we believe that the information provided by Criterion A can be substituted by the presence or absence of a set of core symptoms, and that it is possible to omit Criterion A without any loss of accuracy, selectivity, or validity of the diagnosis of PTSD. Why is this desirable? First, as reviewed above, there is abundant evidence that existing symptoms in clusters B–D are commonly reported in response to a wide variety of stressful situations, whether traumatic or not. It is also striking that other anxiety disorders (e.g., social anxiety, panic disorder, OCD) have far simpler diagnostic criteria and generally contain a core defining feature that can be recognized with a high degree of reliability. It is an empirical question whether PTSD could be similarly simplified. Consistent with this possibility, however, there is evidence that screening measures with as few as 4 to 6 items perform as well as longer instruments containing the full 17 items specified in *DSM-IV* in detecting current PTSD (Brewin, 2005).

Our proposal is that PTSD should be refocused around the core phenomenon of reexperiencing in the present, in the form of intrusive multisensory images accompanied by marked fear or horror, an event now perceived as having severely threatened a person's physical or psychological well-being. The intention is to highlight the features that are most salient to the individual with

PTSD, that are the primary focus of psychological treatment, and that make PTSD distinct from other anxiety disorders and from depression. Images may be visual, auditory, olfactory, somatosensory, or a combination of these. The reexperiencing symptoms need to be supplemented by other, closely related symptoms that are as far as possible specific to PTSD and are less likely to reflect general dysphoria. Thus, the current diagnostic criteria could be amended to read as shown in Table 1, involving a reduction from 17 to 6 core symptoms. Five of these six symptoms were found to be among the most highly predictive of a PTSD diagnosis in the *DSM-IV* Field Trial (Kilpatrick et al., 1998).

These criteria emphasize once more the actual symptoms currently reported by patients rather than their accounts of past events, recognizing that the significance of those events may be changed by subsequent psychological and biological developments. There is an explicit focus on the emotions of fear and horror, recognizing that there are related but probably distinct disorders in which intrusive memories and images are accompanied by other emotions such as anger, guilt, shame, or sadness, but not by fear or horror. Finally, it is important to emphasize that, like many other disorders, PTSD is unlikely to occur in isolation and will typically

Table 1. Proposed Diagnostic Criteria for Posttraumatic Stress Disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*

Criterion B (Reexperiencing—should be present in past month or, exceptionally, on examination). Either:

- (i) recurrent distressing dreams related to an event now perceived as having severely threatened someone's physical or psychological well-being, from which the person wakes with marked fear or horror, or
- (ii) repeated daytime images related to an event now perceived as having severely threatened someone's physical or psychological wellbeing, experienced as recurring in the present and accompanied by marked fear or horror

Criterion C (Avoidance—should be present in past month).

Either:

- (i) efforts to avoid thoughts, feelings, conversations, or internal reminders associated with the reexperienced event(s), or
- (ii) efforts to avoid activities, places, people, or external reminders associated with the reexperienced event(s)

Criterion D (Hyperarousal—should be present most days in past month). Either:

- (i) hypervigilance, or
- (ii) exaggerated startle response

Criterion E (Duration): Duration of the disturbance is more than 1 month.

Criterion F (Impairment): The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

be comorbid with depression, substance abuse, anxiety disorders, more complex dissociative presentations, etc.

POTENTIAL ADVANTAGES AND DISADVANTAGES OF THE PROPOSED DIAGNOSTIC CRITERIA

Abolition of Criterion A

Among the possible advantages of not requiring a trauma is that PTSD will immediately come into alignment with all other psychiatric disorders, and one major source of controversy will have been eliminated. Posttraumatic stress disorder will now be much more comparable with the other anxiety disorders and with depression. There will no longer be a problem deciding whether the reexperienced event qualifies for Criterion A, or depending on retrospective reports of what emotions were felt, and how strongly, many months or years previously. Individual vulnerability, professional training to face traumatic events, and changing perceptions of events over time, will no longer disqualify individuals from being diagnosed with PTSD. Clinicians will be free to focus on the symptomatic presentation and on the most appropriate treatment, free of concerns that someone will decide that a survivor of trauma "could not have PTSD" because the events lived through were not on a list established by a limited number of studies, or because the "right" emotions were not felt at the time. Any risk of a return to the pre-*DSM-III* state of affairs when the treatment needs of individuals with PTSD were not recognized would be minimized.

Two objections to abolishing Criterion A were recently articulated by Weathers and Keane (2007). One was that it would result in a substantial departure from the original conceptualization of PTSD. In our view that conceptualization *should* now change substantially to reflect the wealth of new research findings on risk factors, traumatic memory, etc. It has become clear that a traumatic event does not have the etiological status that was originally envisaged, but that it interacts in a complex way with the individual characteristics of the affected person. Their second objection was that it would risk trivializing the suffering of those exposed to catastrophic life events. We believe that, unlike in 1980, it is now clearly established that traumatic events can have a severe and long-lasting impact on mental health. We anticipate that meeting the new criteria for PTSD will continue to be very strongly associated with exposure to events meeting the former Criterion A, and that these events will continue to be identifiable through the content of the reexperiencing symptoms. Our concern is rather that having the etiological criterion places excessive emphasis on PTSD as the primary outcome of catastrophic events and impedes recognition of other common outcomes such as depression, phobia, GAD, somatoform disorders, substance abuse disorders, etc.

Another potential objection is that without the gatekeeper function of Criterion A the scope of PTSD will be widened to include reactions to almost any stressor, and that the diagnosis will become

meaningless as a result. We believe the existing data suggest this is unlikely to occur, and that in any case the accompanying increased focus on core symptoms, together with the impairment criterion, will prevent this from happening.

Focusing on Core Symptoms

The increased focus on a core disturbance, and the consequent simplification of the criteria, should lead to improved ease of identification and diagnosis in settings other than specialist trauma centers. The removal of symptoms associated with general dysphoria should also lead to greater homogeneity of cases and reduced overlap with other disorders. In keeping with the emphasis on the underlying psychological process, the criteria additionally give clinicians greater flexibility in identifying reexperiencing on examination. Highly avoidant patients may not have had reexperiencing symptoms in the past month even though they know what situations continue to trigger them and the symptoms are readily apparent when they describe their trauma. Finally, the explicit focus on the reexperiencing of fear and horror should encourage better links with basic psychological and neuroscience approaches to these emotions.

One disadvantage of the proposals is that there may be disagreement about what constitutes the core of the disorder. North, Suris, Davis, and Smith (2009) have recently proposed that the defining features of PTSD are the avoidance and numbing symptoms, partly on the grounds that this symptom cluster is less commonly endorsed than the others, and that meeting the threshold for these symptoms is more predictive of subsequent disorder than meeting criteria for the reexperiencing or hyperarousal symptoms. However, much of the evidence on which this argument is based does not distinguish clearly between effortful avoidance and emotional numbing, which appear to be distinct dimensions with different underlying mechanisms (e.g., Elklit & Shevlin, 2007; Foa, Zinbarg, & Rothbaum, 1992; Simms et al., 2002). It is important both practically and theoretically to know whether it is numbing, avoidance, or both that account for the predictive power of this symptom cluster. Another problem is that the numbing symptoms are those that overlap most with depression (Simms et al., 2002), rather than being a distinctive characteristic of PTSD.

CONCLUSION

The controversy over the PTSD diagnosis and the uncertainty over how to frame Criterion A have not abated with the passage of time or with increasing knowledge. Critics of PTSD have frequently had valid points to make, but have less often made constructive suggestions for its improvement. We believe the value of the diagnosis itself is clear, but that its dependence on the etiological criterion is now more of historical interest rather than practical importance. Further, the symptomatic overlap with other disorders has tended to impede research into underlying processes, and to obscure links

with the psychology and biology of emotion. It may also have given a false impression of the degree of comorbidity associated with the disorder. We believe that PTSD has now come of age in the sense of being accepted as a distinct and important condition with its own range of evidence-based, targeted treatments. In our view it is time to consider a reformulation of the diagnosis built on the formidable knowledge base that has accrued in the last 30 years.

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