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View Point

PTSD – DSM 5 Versus ICD 11, Conceptual Differences, and its Relevance to Developing Countries

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According to a WHO survey on mental disorders, 3.9% of the world's population will have post-traumatic stress disorder (PTSD) at some stage in their life. Around 70% of individuals will encounter a traumatic event during their lifetime, yet only a small percentage (5.6%) will develop PTSD.[1]

Although originally associated with war, PTSD is now conceptualized in various ways. Originally, symptoms resembling PTSD were identified by two neurologists, Jean-Martin Charcot, and Oppenheim, while caring for individuals affected by railroad incidents and industrial accidents.

In 1880, Charcot described "Traumatic Hysteria" as a condition of the mind that arises not from physical damage but from the mental state associated with it. He postulated that intense fright, processed through unconscious processes, would lead to symptoms and depend on the patient's ideas of the trauma.

However, Oppenheim differed from Charcot. In 1889, while treating various victims of accidents, he postulated the concept of "Traumatic Neurosis," in which he emphasized the importance of physical shock. Though he acknowledged the role of psychological shock in the absence of physical trauma, he stressed that this affected the nervous system rather than the mind.[2]

The debate continues, and there have been many changes in the definition of trauma and exposure to it. The inclusion of PTSD in DSM-III led to the recognition, treatment, and rehabilitation of veterans. Earlier, it was classified as "Post-Vietnam Syndrome" or "Rape Victim Syndrome."[2] It was believed that there are common unifying pathways for different traumas, which validates PTSD as a clinical condition.

However, the persistence of trauma in developing countries and war-like situations in many regions has led to different approaches to PTSD.

DSM-5[3] has constructed and conceptualized the disorder based on the nature of trauma, symptoms arising due to exposure, and subsequent changes in mood, cognition, and behavior. The symptom clusters are organized within the following framework.

1. Exposure to actual or threatened death, serious injury, or sexual violence.
2. Recurrent, involuntary, and intrusive distressing memories, recurrent distressing dreams, dissociative reactions like flashbacks of the traumatic event, and cues related to psychological distress.
3. Persistent avoidance of distressing memories, thoughts, and feelings and of external reminders that arouse distressed memories, thoughts, and feelings associated with the traumatic events.
4. Negative alterations in mood and cognition like dissociative amnesia, persistent and exaggerated negative beliefs, and persistent negative emotions with an inability to experience positive emotions.

5. Marked alterations in arousal and reactivity with irritable behavior, self-destructive behavior, hypervigilance, exaggerated startle response, and sleep disturbance.

Diagnostic and statistical manual of mental disorders, fifth edition, (DSM-5) also introduced two specifiers: one with dissociative symptoms such as depersonalization or derealization and one with delayed expression, where the criteria are not met until 6 months after the trauma. The late-onset specifier is intended for situations where individuals do not immediately display full symptoms.[3]

As conceptualized by International classification of diseases 11th revision(ICD) 11,[4] *"Post-traumatic stress disorder (PTSD) is a syndrome that develops following exposure to an extremely threatening or horrific event or series of events that is characterized by all of the following:*

1. *Re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares, which are typically accompanied by strong and overwhelming emotions such as fear or horror and strong physical sensations or feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event.*
2. *Avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and*
3. *Persistent perceptions of heightened current threat, for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises.*

The symptoms must persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

ICD-11 has introduced a new category of disorder known as Complex Post-Traumatic Stress Disorder (C-PTSD) that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The core symptoms of PTSD characterize the disorder; that is, all diagnostic requirements for PTSD have been met at some point during the disorder.

In addition, complex PTSD is characterized by

1. *Severe and pervasive problems in affect regulation*
2. *Persistent beliefs about oneself as diminished, defeated, or worthless, accompanied by deep and pervasive feelings of shame, guilt, or failure related to the traumatic event; and*
3. *Persistent difficulties in sustaining relationships and in feeling close to others.*

The disturbance causes significant impairment in personal, family, social, educational, occupational, or other important areas of functioning."[4]

The differences between DSM-5 and ICD-11 in conceptualizing PTSD have important implications for developing countries. The introduction of complex PTSD allows for the diagnosis of individuals suffering from chronic trauma due to ethical, political, and religious conflicts, exploitation, and domestic violence. This addition will help in recognizing and providing support to these individuals. Additionally, there is a greater understanding of cultural variation in symptom formation and resilience due to religious and cultural beliefs, making the framework more adaptable to the diverse challenges faced in developing countries.

Ethical approval

Institutional Review Board approval is not required.

Declaration of patient consent

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Use of artificial intelligence (AI)-assisted technology for manuscript preparation

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