Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and the Impact of Events Scale-Revised

To the Editor:

We read with great interest the article by Bienvenu et al1 in a recent issue of CHEST (July 2013) and would like to complement them on the development and validation of the Impact of Events Scale-Revised (IES-R) for patients with posttraumatic stress disorder (PTSD) after acute lung injury. Psychiatric nosology and diagnostic classification systems are always dynamic and in a state of flux. The authors developed the screening questionnaire and validated it against the Clinician-Administered PTSD Scale (CAPS), which is based on Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth edition, diagnostic criteria. However, the recently introduced fifth edition (DSM-5) has revised the conceptualization as well as the diagnostic criteria for PTSD, which has definite implications for the screening instrument proposed in the study.

PTSD was moved from the class of anxiety disorders into a new class of trauma and stressor-related disorders. The cluster of symptoms in the fourth edition has been expanded in DSM-5 to include intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. DSM-5 now requires at least one avoidance symptom for a PTSD diagnosis. Three new symptoms were added: two in criteria D (negative alterations in cognitions and mood) to include persistent, distorted blame of self or others and persistent negative emotional state and one in criteria E (alterations in arousal and reactivity) to include reckless or destructive behavior.2 Criterion A2 (requiring fear, helplessness, or others and persistent negative emotional state and one in cognitions and mood) to include persistent, distorted blame of self or others and persistent negative emotional state and one in criteria D (negative alterations in cognitions and mood) to include persistent, distorted blame of self or others and persistent negative emotional state and one in criteria E (alterations in arousal and reactivity) to include reckless or destructive behavior.2 Criterion A2 (requiring fear, helplessness, or horror happening right after the trauma) was removed in DSM-5 because research suggested that this criterion does not improve diagnostic accuracy.3 A clinical subtype with dissociative symptoms was added for those who meet the criteria for PTSD and experience additional depersonalization and derealization symptoms.4

CAPS, the psychometric instrument against which the IES-R was validated, is currently being revised to ensure its compatibility with DSM-5 diagnostic criteria for PTSD. These changes lead to the inference that the IES-R would require substantial revision and validation against the revised CAPS to ensure its clinical utility in the future.

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REFERENCES


Response

To the Editor:

We thank Drs Gnanavel and Robert for their comments on our recent article in CHEST,1 and we appreciate the opportunity to respond. Importantly, we cannot take credit for developing the Impact of Event Scale-Revised (IES-R).2 We simply assessed its measurement properties against a “gold standard” clinical interview, the Clinician-Administered Posttraumatic Stress Disorder Scale, in survivors of acute lung injury.

Drs Gnanavel and Robert highlight the shifting nature of psychiatric diagnosis with successive editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). We conducted our study during the era of the fourth edition (DSM-IV), but the fifth edition (DSM-5) was published a few months ago. Notably, the definition of ARDS has changed since we conducted our study, and the previous umbrella term “acute lung injury” has been eliminated.3

Where we may disagree with Drs Gnanavel and Robert is in their statement that DSM-5 changes necessitate substantial revisions to the IES-R to ensure its future clinical utility. To us, a posttraumatic stress disorder (PTSD) measurement tool has clinical utility if it addresses whether a person has substantial PTSD symptoms and whether symptom levels measured using the tool correlate with symptom levels measured using a clinical interview. Although there are changes in the DSM-5 definition, which include separation of the avoidance and numbing criteria and expansion of the potential associated symptoms from 17 to 20, in our view, the phenotype for PTSD is very similar in DSM-IV and DSM-5. Thus, regardless of whether the authors of the IES-R or other researchers further revise the instrument, it already meets our standard for clinical utility, whether PTSD is defined using DSM-IV or DSM-5.

As highlighted by Schelling and Kapfhammer4 in the editorial accompanying our article, tools such as the IES-R have a potentially important role to play in research and clinical practice because critical illness/intensive care-related PTSD symptoms are common5 but often overlooked. We encourage ongoing discussion and research in this area and thank Drs Gnanavel and Robert for raising these issues.

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