

Post-traumatic Stress Disorder in the DSM

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Statement to the

Institute of Medicine

Board on Population Health and Public Health Practice

Board on Military and Veterans' Health

February 13, 2006

Good afternoon. I am Darrel A. Regier, M.D. M.P.H. I am pleased to have this opportunity meet with you representing the American Psychiatric Association, where I am Director of the Division of Research and Executive Director of the American Psychiatric Institute for Research and Education.

The American Psychiatric Association is responsible for the preparation, publication, and maintenance of the Diagnostic and Statistical Manual of Mental Disorders, which is now in its fourth edition (DSM-IV). Thus, we have a vital interest in the work of this committee, and particularly in VA's request that the IOM committee "review the utility and objectiveness of the criteria in the DSM-IV."

As you have heard from many experts, there is a long history, beginning early in this century, with the notion of "shell shock" in World War I and the analytic concept of "traumatic neurosis." During WW-II and extending to the present, there has been increasing scientific interest in stress reactions to combat and other severe, psychologically traumatizing life events. Work over the past 50-plus years has resulted in a professional consensus, based increasingly on a rigorous scientific base, of the explicit clinical characteristics of the disorder, its prevalence, and its responsiveness to appropriate treatment.

We understand that the VA has a concern about the use of the diagnosis of PTSD in active duty and discharged military personnel and the impact of this diagnosis on the

determination of health benefits and compensation for service-induced disability.

Although separate panels have been asked to address the issue of diagnostic criteria (including screening instruments) and treatment response in the first panel, and compensation issues in the second panel, there is clearly an intermediate and linked issue of severity and disability assessments associated with this and all other mental disorder diagnoses.

All mental disorders – ranging from mild depression to schizophrenia to PTSD – vary in the disability associated with a particular diagnosis. Hence, questions of disability and severity are at the heart of compensation assessments for SSDI and SSI in the civilian sector. However, it is important for all clinical, research, insurance claims management, and governmental use of mental disorder diagnoses to have a common frame of reference for diagnostic assessments. Without such a common reference point, the potential for the development of idiosyncratic diagnostic systems can lead to a dysfunctional and non-cumulative research base and to misuse of diagnostic approaches for financial or political purposes.

I hope it will be helpful to the committee to have some additional background information about the diagnosis and reporting of mental disorders in the U.S. and internationally. After the development of the United Nations in the late 1940's, each signatory to the UN Charter agreed to use the World Health Organization (WHO) International Classification of Diseases (ICD) for all morbidity and mortality recording—to assure comparable international health statistics. Within the U.S., there has been a

Clinical Modification (CM) of the ICD codes since about 1977 when the ninth revision (ICD-9) was issued by the WHO. Although there was a list of mental disorder definitions included in the ICD-9-CM, the NIMH supported research community began using a much more detailed set of explicit Research Diagnostic Criteria (RDC) to obtain greater homogeneity of research subjects. In 1980, the APA proposed a third edition of the Diagnostic and Statistical Manual (DSM-III) that was based heavily on the RDC prototype of explicit diagnostic criteria, that could be seen as testable hypotheses for their validity in predicting clinical course, treatment response, and eventual etiological information such as genetics or environmental exposure.

This diagnostic prototype was almost immediately adopted by the international psychiatric community, convened by the WHO Division of Mental Health in a historic 1982 Copenhagen conference. The WHO then worked jointly with the APA and NIMH over the next decade, using the DSM-III as a common reference point, to develop almost identical diagnostic criteria for ICD-10 and DSM-IV. Unfortunately, the U.S. has not yet adopted the ICD-10-CM and continues to use ICD-9-CM diagnostic codes for required Medicare claims submissions by the Centers for Medicare & Medicaid services (CMS) (and by private insurance carriers as well). However, for the past 26 years, mental health and other health care practitioners have been using an alternative set of “descriptors” for ICD-9-CM codes, provided in successive editions of the DSM by the American Psychiatric Association (APA).

This alternative classification system for mental disorders is the Diagnostic and Statistical Manual of Mental Disorders, now in its 4th edition (called DSM-IV). Even though the American Psychiatric Association publishes the DSM-IV, psychologists, social workers, counselors, mental health administrators, and policy planners use it routinely for communication, clinical management, and record keeping. Epidemiological surveys and studies of mental health practice patterns use DSM-IV definitions for ascertainment of caseness. Practice guidelines for improving and standardizing patient care are keyed to the DSM definitions. Virtually all research studies on mental disorders define study populations in terms of the DSM categories. Students of medicine, law, psychiatry, psychology, social work, and all other mental health professions rely on textbooks that describe mental disorders based on the DSM definitions.

Furthermore, DSM-IV is the *de facto* official code set for various federal agencies and for virtually all states. Indeed, there are over 650 federal and state statutes and regulations that rely on or directly incorporate DSM's diagnostic criteria. For example, the Department of Veterans Affairs disability program uses the diagnostic criteria in DSM-IV to assess whether an applicant qualifies for disability on the basis of a mental disorder [38 CFR § 4.125]—which is the reason why the VA is sponsoring this IOM review. In addition, CHAMPUS requires that the “mental disorder must be one of those conditions listed in the DSM-III” [32 CFR § 199.2]; and Medicaid beneficiaries who apply for admission to nursing facilities because of a mental disorder must meet diagnostic criteria set out in DSM [42 CFR § 483.102]. In California, Medicaid reimbursement to hospitals is keyed to the DSM-IV [9 CCR §§ 1820.205(a)(1)(B) and 1830.205(b)(1)(B)], while in

Tennessee, the mental health qualifications to serve as a police officer incorporate by statute DSM [Tenn. Code Ann. § 38-8-106], as do the driver's license provisions of Pennsylvania law [67 Pa. Code § 83.5].

APA is in the process of assessing the evidence base for PTSD and all other mental disorders in anticipation of a revision of the DSM now scheduled for 2011. In June 2005, APA, with the collaboration of the World Health Organization and grant support from the National Institutes of Health, convened an international research planning conference on stress-induced and fear circuitry disorders, a diagnostic grouping that subsumes PTSD. The conference was co-chaired by Dennis Charney, MD on your panel, and by Gavin Andrews, MD who is an Australian professor of psychiatry and epidemiology,

A key product of the APA/WHO/NIH conference will be the compilation of specific recommendations for research, based on a critical assessment of the existing science base and our identification of near-, intermediate-, and longer-term opportunities for diverse studies and analyses. Papers presented at this conference are now being readied for an APA monograph that will be published late in 2006. In early March, APA will appoint an official DSM-V Revision Task Force. In turn, we will establish a work group on stress-related disorders, including PTSD, which will recommend any modifications to the diagnostic criteria that are supported by the science base.

We look forward to the intensive review that will be conducted by this panel, which may also be informed by some of the papers that have been collected in the previously

mentioned research review conference. Any additional information that is specific to the Veteran's population from emerging from your review will certainly be most welcome by the DSM-V committee that will be convened shortly.

In closing, we hope that information specific to the Veterans population will be incorporated into the U.S. and international diagnostic conventions for mental disorders rather than develop into an idiosyncratic diagnostic system unique to the VA or to the Department of Defense. Likewise, we would hope that there will be a similar interaction with experts convening the large study of mental disorder disability assessment, treatment management, and compensation being supported by the Social Security Administration. One instructive source for these and other expert groups may be found in the work and decisions of the United Nations Compensation Commission, a subsidiary of the U.N. Security Council. The Commission was established in 1991 to process claims and pay compensation – including compensation to claimants who suffered personal injury and mental pain and anguish – resulting from Iraq's invasion and occupation of Kuwait. A common goal for both civilian and military populations is to structure the most effective strategies for maximizing treatment response and functional capacity in those impacted by disability associated with a mental disorder.

Thank you very much.