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Review

Does one size fit all? Nosological, clinical, and scientific implications of variations in PTSD Criterion A

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ABSTRACT

Posttraumatic stress disorder (PTSD) is a psychiatric pathology wherein the precipitating traumatic event is essential for diagnostic eligibility (Criterion A). This link is substantiated throughout PTSD's development as a diagnosis. However, while traumatic events may vary considerably, this variation currently bears nearly no implications for psychiatric nosology. Consequently, PTSD remains a semi-unified diagnostic construct, consisting of no Criterion-A-determined subtypes of adult PTSD. The question addressed by the current paper is then does one size truly fit all? Making an argument for the negative, the paper briefly reviews complex PTSD (CPTSD), ongoing traumatic stress response (OTSR), and cumulative traumas, all of which are exemplars wherein Criterion A specification is crucial for understanding the emerging symptomatology and for devising appropriate interventions. Indicating several overlooked discrepancies in the PTSD literature, the paper urges for the necessity of a more fine-grained differential diagnostic subtyping of PTSD, wherein posttraumatic reactions are more closely associated with their precipitating traumatic events. The paper concludes by suggesting diagnostic, clinical and societal implications, as well as proposing directions for future research.

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Contents

1. Introduction

It is widely accepted that traumatic events may be extremely pathogenic, giving rise to detrimental physical and psychological aftereffects (e.g., Herman, 1992b; Friedman, Keane, & Resick, 2007;

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Yehuda et al., 2015). In fact, undergoing a traumatic (and indeed traumatizing) event serves as a gatekeeper for the application of the posttraumatic stress disorder (PTSD) diagnosis (American Psychiatric Association [APA], 2013). That is, the precipitating experience is the first criterion of the diagnosis (Criterion A), and only in light of its existence may the remaining psychiatric symptoms (Criteria B–E), and the dysfunction that transpires in their wake (Criterion G), be diagnostically considered as constituents of PTSD. In this respect, PTSD has become famous for being one of the very few psychiatric diagnoses wherein etiology, particularly that of past experience, is an essential constituent of the diagnosis. However, it is precisely this widely consensual association between experience and psychopathology that gives rise to an ostensible diagnostic shortcoming.

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) provides an extensive list of events, all of which may potentially lead to PTSD. These "include, but are not limited to" (p. 274) no less than 35 distinct scenarios. The DSM divides this overwhelming multitude of events into three categories based on manner of exposure to the traumatic event: "directly experienced events" (e.g. participation in combat, physical assault, terrorist attack), "witnessed events" (e.g. observing threatened or serious injury, unnatural death or domestic violence), and "indirect exposure" affecting close relatives (e.g. violent personal assault, suicide, serious injury; p. 274). The symptomatic manifestation of PTSD (i.e., Criteria B–E), however, remains identical, seemingly regardless of the precipitating experience which has given rise to them. But can this be an accurate representation of reality? Does it stand to reason that a car accident with no fatalities would fall into the same category as genocides such as the Holocaust? Is it logical that learning of a family member's catastrophe would bear the same emotional consequences as continuous exposure to ongoing incest? Furthermore, from a clinical perspective, can it be that the treatment devised for addressing a person's reaction to an episode in the recent or distant past (e.g., past child abuse) would be identical to that administered for a person experiencing a current, ongoing and protracted threat (e.g., ongoing civil conflict)? Does a posttraumatic reaction set into play by the person's acts of perpetration (e.g., MacNair, 2002) manifest in the same way as that initiated by victimhood? Although answering all of these questions in detail is beyond the scope of the current paper, clinically and diagnostically they ultimately culminate in the question: can a one-size diagnostic entity really fit all?

Taking the questions above as our point of departure, the current paper seeks to challenge the current status of PTSD as a seemingly undisputable, semi-unified diagnostic entity. More specifically, by highlighting the necessary implications inveterate in PTSD's linking of psychopathology and precipitating event, the current paper aims to propose several steps aimed at furthering a more fine-grained consideration of this link. It is important to note at the outset that although the paper primarily addresses what we see as diagnostic inadequacies, its aim is not only to promote a more precise nosology of PTSD(s), but also, and primarily, to cultivate a more nuanced discourse of posttraumatic reactions for the benefit of clinicians, researchers and patients.

It is then also important to note than when we speak of a "semi-unified diagnostic entity" we do not imply that there is only one way in which PTSD may manifest. On the contrary! Since the general tendency from one DSM to the next has been to add symptoms into the extant diagnosis, PTSD now includes as many as 20 potential symptoms resulting in several thousands of different possible symptom constellations warranting the diagnosis (Galatzer-Levy & Bryant, 2013). And yet, somewhat preposterously, no matter what symptomatic configuration manifests within this wide range, the diagnosis remains one and the same.

Addressing this eventuality, below, we first briefly addresses the emergence and development of the PTSD diagnosis. Sketching this ontogenetic course in broad strokes is intended to demonstrate and underscore the process by which the precipitating traumatic event (Criterion A) has gradually become a pivotal component of the emerging diagnosis (for more comprehensive histories of PTSD in psychology and psychiatry, see Monson, Friedman, & La Bash, 2007; Van der Kolk, 2007, respectively). As this development is sketched, we highlight the downside of this diagnostic unification, and highlight some anomalies that surface in light of the application of the same diagnostic requirements across varying contexts. Subsequently, we turn to a discussion of several variations of trauma and its aftermath. Three exemplars are then discussed, each underscoring a different domain wherein symptomatic manifestations are implicated by one or more characteristics of the precipitating traumatic event. Culminating into the realization that a reconsideration of trauma-related diagnoses is warranted, the paper draws to a close by suggesting manners in which the current state of trauma-related nosology and discourse may be better subtyped and specified to meet patients' needs.

2. The development of PTSD and the centrality of Criterion A

PTSD was introduced into the psychiatric vernacular in 1980 by the DSM-III (APA, 1980), and has been a diagnosis in the making ever since. Now, 35 years and thousands of empirical, clinical, and theoretical studies after its inception, PTSD seems to have conquered the posttraumatic domain in research and practice. Searching the APA PsycNET database, the official indexing system of the American Psychological Association, for works that have 'PTSD' as a referential keyword resulted (as of July 22; 2015) in no less than 12,983 items; while searching for 'posttraumatic stress disorder' resulted in an additional 15,767 hits. However; tracing the diagnosis across its developmental course reveals a very thorny road to success (e.g.; Rosen, 2004) – a road that; as will become evident in the course of this paper; is far from reaching its final destination.

In cases of psychiatric pathologies construed asreactions to adversity, the DSM-I (APA, 1952) offered the diagnostic alternative of "Gross Stress Reaction" (GSR), at the time considered a transient diagnosis to be changed to a "Neurotic Reaction" if symptoms persisted. The DSM-II (APA, 1968) eliminated the GSR diagnosis, and gave clinicians the sole alternative "Situational Reaction," a kind of catchall for pathological reactions to external events, similarly considered a temporary and reversible clinical condition. However, beyond the boundaries of the DSM, a number of syndromes had been acknowledged in the professional literature of that time; all tightly knit to their etiological origins – the specific traumatic event that gave rise to their manifestation. These included: rape trauma syndrome, post-Vietnam syndrome, prisoner-of-war syndrome, concentration camp syndrome, war sailor syndrome, child abuse syndrome, battered women's syndrome, and their like (Friedman et al., 2011). The innovative idea incorporated in the DSM-III (APA, 1980) was then that all of these seemingly disparate phenomena may be aggregated under one diagnosis within the broader class of Anxiety Disorders – PTSD. This was indeed a paradigm shift in the psychiatric consideration of trauma (Jones & Wessely, 2007).

Since parsimony is an important component of any valued diagnostic system (e.g., Schattner, 2015), this was a very fortunate eventuality. The new diagnosis collated the aforementioned syndromes under one umbrella term for the benefit of all who were interested primarily in pathways to symptom relief – researchers, clinicians and patients alike. Facilitating this aggregation, however, were not merely the commonalities of the symptoms themselves, for notably these shared common features with other disorders as

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well. Rather, what made these syndromes cluster together was the centrality of an anteceding event that precipitated the symptoms. This event has come to be recognized as PTSD Criterion A.

Naturally, in order to aggregate such diverse instances under one umbrella term, it was imperative to reach a consensual definition concerning that which makes an event traumatic. Indeed, the question of "what should" and "what should not" be considered a traumatic event has become a prominent issue concerning the diagnostic validity of PTSD. This issue has repeatedly resurfaced as necessary advances and modifications from one DSM to the next were contemplated (O'Donnell, Creamer, & Cooper; 2010; Weathers & Keane, 2007). One challenge the unified diagnosis facedregarding Criterion A, was that a lack of clarity as to what may be considered traumatic may lead to a "conceptual bracket creep" (McNally, 2003, 2009). That is, once specificity is lost, the definition of PTSD may be so broad that anything may be considered traumatic, and (un)justifiably warrant diagnosis, thus posing a threat for the validity of the diagnosis as a whole (Spitzer, First, & Wakefield, 2007).

Concomitantly, throughout PTSD's development, realizing that experiences which proved to be traumatizing for some were not so for others, conceptualizations have always walked the fine line between specificity and generalization or abstraction. As Weathers and Keane (2007) note, the challenge has always been multifaceted, first and foremost because traumatic stressors vary along a number of dimensions, including magnitude, complexity, frequency, duration, predictability, and controllability. Moreover, "perception of an event as stressful depends on subjective appraisal, making it difficult to define stressors objectively, and independent of personal meaning making" (p. 108). Indeed, posttraumatic reactions are unique in that they are closely tied to personal meanings, appraisals, and previous assumptions (e.g., Janoff-Bulman, 1992; Tuval-Mashiach et al., 2004). These of course cannot be incorporated in diagnostic manuals as they exceed the mandate of the codex. Hence, Criterion A has been refined and re-conceptualized in each edition of the DSM in an attempt to balance the objective and the subjective aspects of trauma and traumatization. This has resulted in a bifurcated Criterion A in DSM-IV (APA, 1994), wherein the first part of the criterion was the objective event (i.e., "events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others") and the second was the subjective experience of the event (i.e., "the person's response involved intense fear, helplessness, or horror"; Criterion A2). Realizing that such a definition is unsustainable, the latter part was eliminated in DSM-5 (APA, 2013) while the former was retained (Friedman et al., 2011). Making mention of this eventuality, while not intended to imply that Criterion A2 is to be reinstated, serves to emphasize that throughout the development of the PTSD diagnosis Criterion A/A1 remained a pivotal aspect of PTSD, and with it the unwavering connection between event and subsequent psychopathology.

A final important step in grounding PTSD in the precipitating event occurred in the DSM-5 (APA, 2013). PTSD and its concomitant symptoms were removed from their initial location in the 'Anxiety Disorders' category, and relocated in a new diagnostic class, namely 'Trauma- and Stressor-Related Disorders.' This eventuality has transpired in the face of several important realizations, primarily that symptom onset was considered to be precipitated by, rather than merely associated with, a specific stressor or traumatic event (Friedman et al., 2011; Resick & Miller, 2009; Rosen & Lilienfeld, 2008). Thus, although there have been some objections regarding Criterion A's role in PTSD (e.g., Bodkin, Pope, Detke, & Hudson, 2007; Rosen & Taylor, 2007) and even recommendations to abolish the criterion altogether (Brewin, Lanius, Novac, Schnyder, & Galea, 2009), the Gordian knot between the trauma and its aftermath was further substantiated as a prominent and indispensable component of the diagnosis.

2.1. An unfortunate ramification of the unification of trauma related disorders

For the most part, the emergence and development of the PTSD diagnosis delineated above fostered a positive change, as it enabled a proliferation of research and clinical observations focused on one unified phenomenon. However, this diagnostic parsimony may be a double-edged sword. The emerging unified PTSD diagnosis came at the price of forfeiting the discrete qualities of its constitutive syndromes, which have become diagnostically non-existent. The aforementioned disparate syndromes dissipated as they were molded into the new diagnosis aspiring to fit all.

Unsurprisingly, throughout the years an opposing process gradually began to materialize, mainly beyond the discourse of diagnostic and nosological conceptualizations. The posttraumatic literature once again began witnessing the rise of novel concepts, all strongly associated with PTSD. These included, for instance, *betrayal trauma*, primarily related to family abuse and incest (e.g., Freyd, 1996); *perpetration-induced traumatic stress* (e.g., MacNair, 2002) and *moral injury* initially associated with veterans as perpetrators (e.g., Litz et al., 2009; Shay, 2014); as well as *complex PTSD* (e.g., Herman, 1992a) and *Developmental Trauma Disorder* (Van der Kolk, 2005) concerning the reaction to past prolonged periods of child abuse within a relationship of care. Similarly, clinicians began to acknowledge that individuals may be traumatized vicariously without ever being the primary victims (i.e., by witnessing or indirect exposures), a notion best captured in concepts such as *secondary traumatization* and *vicarious traumatization* (e.g., Figley, 1995; McCann & Pearlman, 1990; respectively). Just like other phenomena, reactions to vicarious exposures were also assimilated into the PTSD construct and have thus lost their unique qualities (Horesh, 2015).

To the best of our knowledge, although these terms all have in common the existence of a governing experiential etiological component, and despite several implications for symptomatic manifestation and treatment, they have never been suggested as diagnostic entities (save for CPTSD and developmental trauma disorder, the former of which will be discussed in more detail below) and thus never really entered into the diagnostic discourse and nosology. Rather, they have been in some way incorporated into the PTSD diagnosis. This may be because the consideration of these phenomena has always stemmed from that of PTSD, and it is within PTSD's conceptual framework and measurement that they have gained their meanings; or otherwise that they have not yet gained enough evidence or political support for such proposals.

The above are but a few examples of the conceptual proliferation evident in the trauma literature. However, they are sufficient for suggesting the necessity of a more specified, sub-typical consideration of PTSD. This appeal is reinforced by the findings indicating that different traumas vary considerably in their resulting psychopathological outcomes, including prevalence and symptom configuration. PTSD prevalence, for instance, differs significantly between as well as within genders and populations (e.g., Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yehuda et al., 2015). For instance, rape may be over 40% more likely than a natural disaster to result in PTSD for both men and women, and physical abuse is nearly four times more likely to result in PTSD than witnessing a traumatic event for men, and nearly seven times more likely for women (Kessler et al., 1995). Similarly, the examination of PTSD trajectories reveals that men who rate combat trauma as their worst lifetime experience exhibit higher rates of delayed PTSD onset than those who rate other experiences as most traumatic (Prigerson, Maciejewski, & Rosenheck, 2001).

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Finally, research has shown that symptom presentation and comorbidity differ as the 'worst-event' leading to traumatization varies (Pietrzak et al., 2014; Smith, Summers, Dillon, & Cougle, 2016). For instance, undergoing personal violence was more likely to result in the development of a post-traumatic substance use disorder following PTSD diagnosis, while undergoing an unexpected death of a loved one was associated with greater likelihood of depression onset following the time of the worst-event (Smith et al., 2016).

Considering symptom manifestation, in one study the bereaved were found to exhibit more posttraumatic growth (i.e., the positive psychological change experienced as a result of adversity, such as new meaning, greater appreciation of life and a changed sense of priorities) than other traumatized groups, and those who have been sexually abused reported greater posttraumatic distress compared to survivors of motor vehicle accidents and the bereaved (Shakespeare-Finch & Armstrong, 2010). Similarly, in a recent preliminary study among veterans, veterans with combat trauma were more likely to experience diminished interest and detachment and estrangement from others, while those who have undergone sexual trauma in the military were likely to experience detachment and estrangement from others, sleep disturbances, and problems with concentration, and veterans with civilian traumas were less likely to meet criteria for PTSD and were less likely to experience a number of PTSD symptoms altogether (Graham et al., 2016). Arguably, if the nature of the traumatic events does not affect the emerging psychopathology, it would stand to reason that such significant variances in posttraumatic aftermaths would not be evident.

Regardless of the above, PTSD's symptomatic criteria (Criteria B–E) have not changed in accordance to variations in Criterion A. We then reiterate the question posed at the outset of this paper: does one size truly fit all? The literature above, as well as that addressed below, suggests that the answer may indeed be in the negative. To further substantiate this claim, we now turn to the explication of three reactions to trauma which necessitate a differential trauma-specific diagnostic system. As evident below, this differentiation has become necessary both due to variations in the precipitating events, and due to variations in the resulting aftermaths, which, combined, bear important implications for clinical practice.

3. Variations in trauma and its aftermath

An examination of the trauma literature reveals that while the DSM-5 (APA, 2013) fails to discern posttraumatic reactions in relation to the specifics of their anteceding traumatic events, some such distinctions may nevertheless be in order. Given that diagnostic distinctions must be made primarily according to symptoms, presented below are several of the most significant instances wherein specific traumatic events purportedly lead to specific symptomatology. Moreover, in the cases presented below, the link between event and aftermath is imperative in order for the latter to be adequately addressed. Three cases were chosen for this task, though undeniably other cases may be similarly addressed. Each exemplar relates to a different domain wherein differential diagnosis may be necessary. The first exemplar addresses Complex PTSD (e.g., Herman, 1992a), thus underscoring the different content or quality of the trauma by comparing extreme repeated traumas to single traumatic episodes. The second case, highlighting the necessity of a temporally sensitive consideration of the trauma, discusses the differential aspects of Ongoing Traumatic Stress Response (OTSR; e.g., Diamond, Lipsitz, & Hoffman, 2013) compared to past adversity. The final example, bringing to the fore the aspect of quantity and multiplicity of traumatic events, focusses on cumulative traumas (e.g., Kira et al., 2013), raising the issues of symptom-event-attribution, symptom variety, and severity. We review each of these and demonstrate the manner by which they deviate from classical PTSD both in significant aspects concerning the events which have given rise to the pathology and in the resulting aftermaths.

3.1. Complex PTSD/DESNOS: beyond PTSD

Complex PTSD (CPTSD), also addressed in the literature as *Disorder of extreme stress not otherwise specified* (DESNOS; e.g., van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), has been proposed by numerous clinicians and researchers as a diagnostic category for over two decades (e.g., Ford, 2015; Herman, 1992a, 2012). However, although demonstrating clinical significance (e.g., Cloitre et al., 2010, 2011; Dorrepaal et al., 2014), and thus gaining sufficient evidence to be included in the forthcoming *International Classification of Diseases* (ICD-11; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Knefel & Lueger-Schuster, 2013; Maercker et al., 2013; Wolf et al., 2015), it nevertheless remains highly controversial and contested (e.g., Resick et al., 2012), and thus excluded as a differential diagnosis in the DSM-5 (APA, 2013).

The guiding rationale for CPTSD is that complex traumatic events, such as protracted abuse in early childhood, lead to complex posttraumatic reactions which go beyond the symptoms of classical PTSD. Moreover, CPTSD proponents contend that understanding the pathologies encapsulated by CPTSD as adaptations or rationally valid reactions to trauma, rather than phenomena unrelated to it, may facilitate better clinical practice in these instances (e.g., Courtois, 2004).

Although CPTSD stems from classical PTSD, the syndrome varies from classical PTSD in several important aspects. One significant difference concerns the nature of the events precipitating the two conditions. CPTSD is, by definition, precipitated by events that are (a) repetitive and prolonged, rather than a single traumatic event, (b) involve harm or abandonment by someone who is ostensibly responsible for the victim, and (c) typically occur at developmentally vulnerable periods in the victim's life, particularly childhood (e.g., Cloitre et al., 2009; Ford & Courtois, 2009; Sar, 2011). While originally conceived to address the effects of protracted child abuse and incest, CPTSD has also been adopted for understanding the aftereffects of traumatic events consisting of prolonged domination by any malevolent perpetrator over another person. These include cases of refugees (Palic & Elklit, 2014), former prisoners of war (Herman, 1992b; Solomon, Dekel, & Mikulincer, 2008) and combat veterans (Newman, Orsillo, Herman, Niles, & Litz, 1995).

More importantly, from a diagnostic perspective, is the accumulating evidence indicating symptomatic differences between classic and complex PTSD. Three highly interrelated symptoms have been identified as cardinal characteristics of CPTSD, while only optional and contingent in classical PTSD: somatization, dissociation, and affect dysregulation (Van der Kolk et al., 1996). More recent research focusing on DESNOS (Van der Kolk et al., 2005) has identified more distinct features assembled into seven clusters: (a) alterations in regulation of affect and impulses (e.g., suicidal preoccupation, difficulty modulating sexual involvement, excessive risk-taking), (b) alterations in attention or consciousness (e.g., amnesia, transient dissociative episodes), (c) somatization (e.g., chronic pain, cardiopulmonary symptoms), (d) alterations in self-perception (e.g., ineffectiveness, shame), (e) alterations in perception of the perpetrator (e.g., adopting distorted beliefs, idealization of the perpetrator, preoccupation with hurting the perpetrator), (f) alterations in relations with others (e.g., inability to trust, victimization, victimizing others), and (g) alterations in systems of meaning (despair and hopelessness, loss of previously sustaining beliefs). These symptoms have to some extent been incorporated into the DSM-5 PTSD symptom clusters (e.g., the inception of Criterion D "negative alterations in cognitions and mood," and the specified PTSD with dissociative symptoms), thus

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making the differentiation between PTSD and CPTSD all the more difficult.

Particularly, clusters E and F above relate to the fact that CPTSD is invariably a reaction to deliberate, manmade trauma. In this respect, a well-established distinction made in the literature, yet completely disregarded in the DSM, involves the discernment of manmade versus non-manmade trauma. A long line of research indicates that the aftermath of manmade trauma is not only worse than that of non-manmade (e.g., Lancaster, Melka, & Rodriguez, 2009), but is more prone to involve impediments to interpersonal bonds (Charuvastra & Cloitre, 2008). This issue will be additionally addressed below.

An additional defining feature of CPTSD concerns the detrimental impact that a prolonged, distorted, abusive, interpersonal relationship with one's perpetrators has on his or her personality. Such personality impediments have driven some researchers to suggest considering the aftermaths of such protracted abuse as *posttraumatic personality disorders* (PPD; Classen, Pain, Field, & Woods, 2006). Typically, such disorders have been conceptualized as PTSD plus Borderline Personality Disorder (BPD). Since CPTSD presents a coherent rationale for aggregating both phenomena under one diagnosis, and since it is difficult to adequately address them as a subtype of BPD (Ford & Courtois, 2014); it is persuasively argued that CPTSD "appears to be the most efficient and well-articulated approach for describing the sequelae of complex trauma as a single syndrome for adults" (Ford & Courtois, 2009, p. 24). Therefore, it is suggested that CPTSD be diagnostically and clinically considered as a subtype of PTSD – an adaptation to trauma which is not exactly classical PTSD and yet not BPD proper. Nevertheless, those who oppose such classification argue that this diagnostic overlap is no more than comorbidity (Resick et al., 2012).

Determining whether CPTSD is a subtype of PTSD or a case of comorbidity is likely to remain an interpretative decision, and thus should be subjected to pragmatic considerations rather than ontological verification. This inevitably comes down to the issue of appropriate treatment. Inclusion of CPTSD as a diagnostic category may facilitate clinical treatment that not only works to alleviate PTSD symptomatology, but also addresses emotion regulation, body malfunction, the restoration of working models, the victim's dissociative processes, and self-defeating behavior (Courtois, Ford, & Cloitre, 2009). In an attempt to demonstratie the utility of such an approach, a clinical trial was conducted wherein the efficacy of skills training in affect and interpersonal regulation (STAIR) followed by exposure therapy was compared with exposure therapy accompanied by supportive counseling. The study revealed that not only were the participants in the experiment STAIR group more likely to achieve sustained and full PTSD remission relative to the control 'exposure' group, but they also produced greater improvements in emotion regulation and greater improvements in resolving interpersonal problems (Cloitre et al., 2010). While more research is needed to make evidence-based assertions, a certain absurdity seems to arise, when recommendations for clinical procedures and protocols (Cloitre et al., 2011) precede diagnostic recognition.

Closing our discussion of CPTSD, it is important to note that the above is not intended to settle the nosological contestation revolving around this condition. Rather, the demonstration above is only intended to highlight the growing need to recognize additional trauma-related psychopathologies in light of their precipitating traumatic events. Further pursuing this goal, we now turn to exemplify this necessity from a different perspective. While the consideration of CPTSD challenges the adequacy of the PTSD diagnosis by highlighting the complexity of the precipitating traumatic event, the next category challenges classical PTSD by addressing the temporal aspect of the trauma and symptomatic manifestation (i.e., the consideration of whether the traumatic event has past, or is it rather present and ongoing at time of assessment). As argued below, such a temporal specification, currently absent in the PTSD diagnosis, bears implications for symptom interpretation as well as for treatment.

3.2. Ongoing traumatic stress response

The literature discussing CPTSD addresses repetitive or protracted traumas and juxtaposes their ramifications against those of single case traumas (e.g., Terr, 1991). However, in both classical and complex PTSD, the trauma typically belongs to the past. Considerably less attention has been devoted to reactions to traumas which are not only prolonged, but ongoing at the time of diagnosis. *Ongoing traumatic stress response* (OTSR; Diamond, Lipsitz, Fajerman, & Rozenblat, 2010) and *continuous traumatic stress* (CTS; e.g., Eagle & Kaminer, 2013) are the most common terms proposed for addressing such traumatic episodes (and are therefore used below interchangeably), but other terminologies are similarly evident in the literature (see Stevens, Eagle, Kaminer, & Higson-Smith, 2013, p. 76; Nuttman-Shwartz & Shoval-Zuckerman, 2015, p. 3). Although the concept of CTS was initially introduced in order to address civil conflict (Straker & the Sanctuaries Counselling Team, 1987) and continues to be used in this context (e.g., Stevens et al., 2013), the term has also been applied to instances of ongoing missile shelling threats (e.g., Diamond et al., 2013), the continuous threat of potential terrorist attacks (Marshall et al., 2007), and may similarly be applied (but currently is not) to continuous urban violence (e.g., Goldmann et al., 2011) and prison violence (e.g., Roach, 2013).

It is well recognized that a primary task in cases of stress involves the restoration of safety and its concomitant sense of security. When such a goal is unattainable, hyperarousal, intrusive catastrophic thinking, and retriggering of traumatic associations are liable to linger, potentially leading to the development of posttraumatic stress reactions (Hobfoll et al., 2007). However, for persons who face an actual, ongoing threat, such a re-establishment of safety may be practically impossible. Therefore, it is argued, the resulting traumatic symptoms in such conditions are grounded in a somewhat rational fear (Diamond et al., 2013). Symptoms include intrusion and avoidance, as in classical PTSD; however, intrusive thoughts are oriented towards the future no less than the past. That is, these individuals are incessantly preoccupied with the anticipation of what is yet to come and not only concerned with their traumatic past. Similarly, avoidance behaviors arise to evade concrete, rather than imagined, danger and are therefore, to a certain extent, adaptive. Put otherwise, while the clinical picture drawn by PTSD assessment measures (e.g., questionnaires) in cases of OTSR may result in an identical clinical picture as that of classical PTSD, the conditions giving rise to the manifestation of these phenomena are nevertheless qualitatively different, as is the significance and meaning of the phenomena themselves.

Suggesting a differential diagnosis in the case of OTSR may strike some as misplaced in the context at hand for two reasons. Firstly, because the trauma is not in its "post" phase, so to speak, and hence the reaction to it, as noted above, may not be considered as entirely maladaptive. Currently, the DSM-V (APA, 2013) fails to address the temporal aspect of the traumatic episode (i.e., past or present), leaving researchers and clinicians the sole choice of treating OTSR symptomatology as PTSD. Doubtlessly, in order to incorporate OTSR within the posttraumatic category, a re-understanding of *"post"* in *"post*traumatic" is in order. As a matter of fact, in cases of OTSR there is a confluence of the peritraumatic (i.e., what occurs within the traumatic episode) and the posttraumatic. The second reason OTSR may seem a misplaced issue in the context of the current paper is due to the fact that the trauma itself (i.e., the event qua event) is no different than events rightfully treated as classical PTSD

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precipitators. As argued below, it is precisely these features which necessitate its separate consideration.

Arguably, regardless of the question of differential diagnosis, the existence and interaction of three parameters deems OTSR a noteworthy trauma- and stress-related psychiatric condition: (a) its abnormality (i.e., statistical prevalence), (b) its maladaptive nature (i.e., resulting dysfunction), and (c) its treatability. In all three respects OTSR differs from classical PTSD. As for the first point, a psychiatric condition is recognized as such only if it deviates "from normal life variation and transient responses to stress" (APA, 2013, p. 5). While OTSR symptoms may be to some extent transient (as, for instance, are those of acute stress disorder) and may subside once the threat is eliminated (Diamond et al., 2010), they remain a deviation from the norm. For instance, in a study by Bleich, Gelkopf, Melamed, and Solomon (2006) investigating the psychological sequelae of 44 months of terrorism among adult Israeli residents, the researchers found that only roughly 9% met criteria for PTSD and reported the need of mental health treatment, while 15% exhibited functional impairment, and about 85% exhibited one or more posttraumatic stress symptoms. Pathological reactions are then far from being the norm, yet they are nevertheless significantly present. Moreover, while these symptoms are indeed transient, they seem to linger for as long as the threat persists, which may be for years on end. Hence, Lahad and Leykin (2010, p. 696) echo their contemporaries' suggestion to generate a new category for defining such subsamples living in ongoing exposure areas, and exhibiting PTSD symptoms only in the affected area but not outside it.

As for the maladaptive nature of symptomatology, it may be argued that although these reactions are logically adaptive in the face of threat, they are nevertheless maladaptive when juxtaposed with the demands of everyday life functioning. Put otherwise, these reactions may be a reasonable (although anomalous) reaction to an abnormal situation, but they remain extremely disruptive of one's quotidian life, and may yet be adjusted and transformed to achieve a more adaptive routine (e.g., Diamond et al., 2013; Nuttman-Shwartz & Shoval-Zuckerman, 2015). This brings us to the issue of treatability.

Ultimately, a major animating force for proposing OTSR as a distinct type of PTSD is clinical. PTSD has given rise to many diverse and effective treatments (Foa, Keane, Friedman, & Cohen, 2008). However, as noted by Marshall and colleagues (2007, p. 305), "All of these treatments are based on the premise that the client's traumatic experiences are in the past (rather than ongoing)," and thus, "little is known about how well these models translate into clinical settings in the context of ongoing terrorist threats." Indeed, in these cases the common denominators of effective treatment for trauma – psychoeducation, exposure, and relaxation – are all altered for the sake of adapting to OTSR's unique manifestation (e.g., Diamond et al., 2013). For instance, psychoeducation efforts in such cases should focus on conveying the message that the individual's anxiety, cognitions, and behaviors may not be inherently senseless or even pathological, but are nevertheless exaggerated and maladaptive. Similarly, rather than exposure to the past event typical of PTSD interventions (Foa, Hembree, & Rothbaum, 2007), exposure in OTSR cases takes the form of preparation for "in-vivo exposures to currently stressful, fear evoking activities and places' (Diamond et al., 2013, p. 21), and the planning of adaptive functional reactions in the face of early warning system onset. These adaptations may only be possible if OTSR is considered in its unique features, thus differentiated from PTSD proper.

Finally, it is not unlikely for researchers and policy-makers to seek-out the prevalence of PTSD in populations exposed to ongoing stress. Naturally, such investigators will administer PTSD assessments, and will inevitably find significant rates of PTSD symptom manifestations. Notably, while the nature of the traumatic event may be similar to that of combat, for instance, symptom manifestation and severity in OTSR may be more extreme. Lahad and Leykin (2010), for instance, compared people exposed to an 8 year ongoing shelling to a group who were exposed to intense periodic shelling, and found the former to exhibit significantly more severe arousal and intrusion symptoms. In light of the important distinctions between PTSD and OTSR delineated above, however, the validity of findings in any such investigation is questionable (Hoffman, Diamond, & Lipsitz, 2011). It then transpires that OTSR and PTSD, whether different or identical in their symptomatic manifestations, differ in the meaning of these manifestations as well as in their treatment due to their etiological sources in their temporal aspect. Indeed, whether we accept or reject the argument that such phenomena are best understood outside of the framework of psychiatric diagnoses (Marshall et al., 2007), it would nonetheless seem important to distinguish these other phenomena from PTSD and probable PTSD.

3.3. Cumulative traumas

In addition to single case, repeated/prolonged, and ongoing trauma, the inclusion of yet another trauma constellation may be necessary, namely, *cumulative trauma* (CT). CT includes those instances which combine several of the former types in a cumulative manner, across one's lifetime. For instance, child sexual abuse, adult sexual assault, and spouse abuse (Follette, Polusny, Bechtle, & Naugle, 1996). Multiple traumatizations, and particularly multiple abuses, go by many names (e.g., polytraumatization, revictimization, retraumatization; see Scott-Storey, 2011 for a review).

Though preliminary, and as of yet insufficiently substantiated, the notion of cumulative traumas as bearing qualitatively different aftereffects than classical PTSD is beginning to gain prominence in the literature. Typically, the examination of single versus cumulative traumas focusses on symptom severity, indicating that cumulative traumas give rise to more severe PTSD symptomatology (e.g., Briere, Kaltman, & Green, 2008; Clancy et al., 2006; Green et al., 2000; Yehuda et al., 1995). However, cumulative traumas were also found to give rise to psychosis (Shevlin, Houston, Dorahy, & Adamson, 2008), greater distress (Williams et al., 2007), more depression (Suliman et al., 2009), and several other psychiatric disorders (e.g., bipolar disorder, general anxiety disorder, social phobia, specific phobia; Karam et al., 2014), indicating that reactions to such cumulative traumas are considerably more complex. In light of their findings, all of the researchers involved in such studies suggest that the assessment of lifetime traumas is imperative when treating PTSD patients.

An additional aspect of cumulative trauma relates to symptom attribution. That is, once posttraumatic symptomatology manifests, to what traumatic event is it to be attributed? One population which may serve to exemplify this conundrum is that of female veterans. Since the American military operations in Iraq and Afghanistan, there has been an increasing amount of literature concerning the ramifications of these military experiences for female veterans (e.g., Boyd, Bradshaw, & Robinson, 2013; Mattocks et al., 2012; Street, Vogt, & Dutra, 2009). What these studies repeatedly indicate is that female veterans are exposed during deployment not only to combat trauma (itself a conglomeration of numerous events) but also to military sexual trauma (i.e., rape, sexual assault and sexual harassment) by their fellow unit members. Making things even worse, at times such traumata may interact also with prior childhood traumas (Scott et al., 2014) and later adult traumas (Kelly, Skelton, Patel, & Bradley, 2011). Thus, during deployment and upon their return, female veterans may suffer from PTSD symptomatology, as well as depression, suicidal ideation and substance abuse (Boyd et al., 2013). However, to the best of our knowledge, currently no effort has been undertaken to investigate how the qualities (rather than

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severity) of the emerging symptoms are associated with either of these traumas, each of which may be related to any of the aforementioned symptoms (e.g., hyperarousal associated with combat exposure and avoidance of interpersonal contact associated with sexual assault).

Symptoms may originate in different traumas, and hence may accumulate in two manners. First, they may accumulate in that each trauma may give rise to different symptoms, and only together do they meet the full range of diagnostic criteria; or they may accumulate in that each event gives rise to two overlapping PTSDs, wherein a full PTSD symptom manifestation relating to each of the traumas individually amasses and accumulates to what may be tentatively termed *multiple posttraumatic stress disorder* (MPTSD) or *cumulative posttraumatic stress disorder* (CUMPTSD). This possibility first implicates assessment, as most PTSD measures are designed to target only one traumatic event in relation to evidencing symptoms (Carlson, 2001). Particularly, in this respect, where severity is measured as the number and intensity of symptoms, it is important to keep in mind that symptoms aggregated under the same category (e.g., Criterion D exemplars of detachment from others, guilt, and diminished interest) are qualitatively different and may best be addressed as reactions to different events. Moreover, and more importantly, treatment must too address the cumulative and multiple traumas if it is to adequately address all causes of impairment and dysfunction associated with posttraumatic outcomes. As traumas vary in their nature, their specific contribution to the cumulative clinical picture may be determined, for instance, according to the degree of betrayal associated with the event (Martin, Cromer, DePrince, & Freyd, 2013), or any other parameter that is found to be relevant during the attempt to trace psychopathology to its traumatic origins. In this respect, cumulative trauma and Complex PTSD are not mutually exclusive, the latter typically a severe exemplar of the former with its own unique features.

Sequential traumatization (e.g., terror, followed by civil conflict, then rape, loss of a family member, and chronic illness), may be cumulative in another sense. Multiple traumas may be cumulative in that they expand the realms of traumatization and make generalization of the trauma a more readily outcome. The individual's resultant conviction that the world is not safe, that there is no meaning to be found in the world, and that there is something in him or her that is fundamentally damaged (Janoff-Bulman, 1992) may then be "grounded" in a host of past "evidence," from a variety of sources and at different points in time. Especially in light of symptoms relating to negative cognitions (Criterion D; APA, 2013), it then stands to reason that treatment would address each trauma piecemeal as well as the cumulative aftermath as a whole.

This consideration of multiple traumatizations also implicates future research in that it calls into question the potentially confounded nature of "worst event" studies. From a cumulative trauma perspective, studies seeking to understand the sequelae of trauma based on the nature of the worst traumatic event (e.g., Pietrzak et al., 2014) risk overlooking the fact that any given event may be just one portion of a cumulative traumatic past. The realization that multiple traumas are more prevalent than single traumas, and may result in a more severe and comorbid clinical picture (e.g., Karam et al., 2014; Kessler et al., 1995) renders this shortcoming a significant threat to scientific credibility. One way to address this is by differentiating single case and cumulative PTSDs. The consideration of cumulative trauma then sets the stage for the discussion of the subtyping of traumatic events and their aftermaths.

4. Discussion

Two main messages are to be taken from the arguments and exemplars above. First, a "one-size-fit-all" approach to PTSD is inadequate, and must be rectified to address varying posttraumatic symptom manifestations. Second, as the PTSD diagnosis and its concomitant nosological discourse are fine-tuned, the precipitating events must be taken into consideration in a threefold manner. First, they are to be addressed as determinants of symptom manifestation (i.e., what symptoms certain events give rise to), as in CPTSD for instance; second, as in the case of OTSR, they are to be apprehended as determinants of symptom interpretation (i.e., assessing the pathological/non-pathological relation between maladaptive behavior and threat appraisals; e.g., Marshall et al., 2007); and third, traumatic events are to be apprehended as indicators of trauma-symptom attribution (i.e., linking evincing symptom to the preceding traumatic event), as implied in the consideration of cumulative traumas.

Reaching a well-informed and scientifically based psychiatric nosology has been an all but insurmountable challenge throughout the years (e.g., Kendler, 1990, 2009; Nesse & Stein, 2012). However, the importance of such a nosology is generally agreed upon. As indicated in the opening statement of the DSM. The current paper may then be another important step in this effort, as it strives to establish a more specific psychiatric nosology of posttraumatic disorders.

> Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. (APA, 2013, p. 5)

Reviewing the development of PTSD as a psychiatric diagnosis (e.g., Monson et al., 2007; Van der Kolk, 2007), one readily comes to realize that PTSD is, and always has been, a diagnosis fashioned by an amalgamation of advances in science (i.e., in psychiatry and psychology), theoretical trends, personal and financial interests (i.e., stakeholders and beneficiaries on both the provider and consumer sides of treatment), and moral commitments towards those who suffer from the aftermath of trauma (e.g., Quosh & Gergen, 2008; Rosen, 2004; Summerfield, 2001). Hence, four major domains are of primary concern: (a) differential psychiatric diagnostics, (b) clinical practice, (c) scientific research, and (d) social and societal responsibilities.

Quosh and Gergen, (2008) note that, "Often, it seems that the helping professions are more engaged in executing a program of diagnosis and treatment than they are in caring for those who suffer" (p. 105). In this respect, the current paper, while ultimately addressing the scientific milieu, is of import first and foremost for those who suffer from trauma's aftermath. It is they who seek explanations for their dysfunction and impairment; it is they who need to make sense of their mental injuries and understand how these are connected to their traumatic experiences; and they who need treatment to accurately address their past and present so such an understanding may facilitate a favorable fashioning of their future. It then transpires that researchers, practitioners and patients can all benefit from a more nuanced PTSD nosology and discourse.

4.1. Psychiatric nosology and the subtyping of PTSD

Exposure to traumatic events is arguably a part of the human condition and as such is vast and universal in scope. And yet, exposures worldwide vary considerably in nature and prevalence (Benjet et al., 2016). As evidenced above, such diverse exposures may lead to diverse posttraumatic reactions. There may be a temptation to classify these variations according to the *dose* of traumatizing content and *severity* of symptoms. However, the

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explication above suggests that both the precipitating traumatic events and the manner in which these events are related to the emergence of subsequent posttraumatic reactions may be qualitatively, rather than merely quantitatively, discernable. Differentiation then may take the form of different symptomatology, as exemplified in our consideration of CPTSD, or in the interpretation of PTSD-like symptoms. Indeed, as stressed throughout this paper, the term '*post*-trauma' entails an *inveterate relation* between an event and its outcome, and it is this relation that gives PTSD its unique existence. However, the ramifications of this relation, and particularly variations on both sides of the event-aftermath equation, have been largely overlooked in previous diagnostic manuals, thus hindering the subtyping of posttraumatic reactions.

Throughout PTSD's development as a diagnostic entity, there have been several proposals suggesting taxonomic subtyping systems. Reviewing several extant PTSD typologies, for instance, Alarcon, Deering, Glover, and Ready (1997) proposed a typology of their own consisting of six clinical types: depressive, dissociative, somatomorphic, psychotomorphic, organomorphic, and "neurotic-like." Similarly, Miller, Kaloupek, Dillon, and Keane (2004) have suggested discerning posttraumatic reactions according to externalizing (e.g., alcohol-related and antisocial personality behaviors) versus internalizing symptoms (e.g., panic and depression). This direction has been further supported by recent research (e.g., Wolf, Miller, Harrington, & Reardon, 2012). None of these, however, attempted to link the differential outcomes to the specific events precipitating their manifestation..

More closely linking potentially traumatic events and posttraumatic reactions, Terr (1991), a theoretical forerunner of CPTSD, discerned Type-I traumas referring to reactions to a single traumatic event, from Type-II traumas which transpire in the face of "long-standing or repeated exposure to extreme external events" (p. 15). As discussed extensively above, each of these types is claimed to bring about somewhat different posttraumatic reactions, the more complex of which are associated with the second type. Alternatively, Solomon and Heide (1999) refer to the more extreme, repeated, sexual and violent type of traumas in childhood as Type-III, while Type-II is reserved by them for "such experiences as repeated fondling by a neighbor or uncle, or growing up with parents who engage in moderate psychological or physical abuse" (p. 204). Pietrzak et al. (2014) evaluated predominant typologies of PTSD in a nationally representative sample of U.S. adults and found three PTSD typologies: Anxious-Re-experiencing, Dysphoric, and High Symptom. The researchers further found that the worst trauma event was associated with different predominant typologies of PTSD, which were associated with different comorbidities. This finding led the researchers to the possible conclusion that "certain trauma exposures may give rise to unique clusters of symptoms that may be etiologically linked to the nature of the traumatic event" (p. 104).

A comprehensive taxonomy wherein traumatic events and posttraumatic reactions are closely linked was suggested by Kira and colleagues (e.g., Kira et al., 2008, 2013; Kira, 2001). First, Kira et al. (2013), like others before them, suggest the addition of the type-III trauma. In their taxonomy, this subtype corresponds with ongoing traumas. Moreover, they also suggest a type-IV trauma classification corresponding with "cumulative traumas along the life span." Concomitantly, a bidimensional, developmentally based stress and trauma framework is proposed and explicated. In the taxonomy, each of the aforementioned four types of trauma (i.e., single, repeated/prolonged, continuous, and cumulative) relate to qualitatively distinct traumatic episodes, categorized according to multiple criteria: (a) threat salience: do they threaten physical integrity, relational integrity, identity integrity, or the integrity of the larger group (e.g., family); (b) the source of the trauma: do they originate in an internal (e.g., illness) or external (e.g., car accident) event; (c) directness of experience: are they directly or vicariously experienced; and (d) developmental stage at time of trauma: are they experienced in a developmentally sensitive or mature stage in one's ontogeny; and (e) cause of trauma: are they manmade (or socially made) versus non-manmade. A taxonomic matrix is then proposed (see Kira et al., 2013; p. 398, Table 1), wherein the different events are matched with type of exposure. Thus, for instance, life threatening illness may be categorized as an internal, non-manmade, type-II, physical trauma experienced directly; whereas human trafficking may be recognized as a type-III identity trauma, which is manmade and directly experienced.

While such distinctions may prove valuable in a clinical setting, and enrich the therapeutic discourse, whether all of these bifurcations are necessary and justified from a diagnostic perspective is yet to be sufficiently determined by empirical research. One may indeed come to ask whether, in light of such a diversity of "traumatic trees," we are not at risk of losing sight of the "PTSD forest". But, keeping with the metaphor, what if we are misled to seeing a forest where there are actually several adjacent or overlapping groves? That is, what if our current "one-size-fits-all" PTSD diagnosis keeps us from appreciating the differential symptomatic manifestations of diverse traumatic events? Indeed, the above considerations strengthen the argument that one size of PTSD may fail to adequately fit all trauma-reaction trajectories (e.g., Kelly et al., 2011). This realization may bear important implications for diagnosticians, clinicians, and researchers alike.

4.2. Diagnostic recommendations

Diagnostic recommendations should be approached with caution, first and foremost because diagnostic specifications strongly depend on empirical research, and truly there is a paucity of research devoted to the relation between specific traumatic events and specific subsequent posttraumatic reactions. Moreover, it is noteworthy that the DSM (APA, 2013) already includes some commendable and important specifications which are not to be overlooked. First, there are two trauma related disorders relating to mistreatment in developmentally vulnerable stages (i.e., *reactive attachment disorder* and *disinhibited social engagement disorder*). Moreover, although not discussed above due to considerations of space, it is noteworthy that the DSM does specify the differential manifestation of PTSD in children less than six years of age compared to adults. Notwithstanding, what the DSM currently lacks in these respects is a consideration of PTSD (or CPTSD) in adults in light of mistreatment or abuse in early childhood. Hence, a developmental sensitivity should be implemented also in the case of adult PTSD. Secondly, the DSM (APA, 2013) specifies two additional cases of PTSD: that with delayed onset and that with dissociative symptoms. However, as noted above, these are not linked to the precipitating traumatic event.

The examples discussed above warrant several additional suggestions concerning Criterion A. First, Criterion A should afford for a specification considering the temporal state of the traumatic event: past, as opposed to present and ongoing as in OTSR. Moreover, such a specification discerning OTSR from classical PTSD may do well to note the correspondence of symptoms and impairment with actual threat, as well as whether symptomatic manifestation and dysfunction disappear when the threat is alleviated. Second, taking into consideration the option of cumulative traumatic episodes and multiple responses, we suggest that the diagnosis discern one from many such PTSDs. Currently, the various criteria refer to "event(s)" (e.g., "intrusive distressing memories of the traumatic event(s)"; APA, 2013, p. 271) as if the extra "s" is of no significance. Given the evidence discussed above, this should be reconsidered.

That said, it is important to note that the exemplars presented above are just that, examples. There may be additional

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Criterion A specifications to be considered, all of which necessitate further research. For instance, the fact that vicarious or secondary trauamtic exposure is currently considered as tantamount to primary traumatic exposure may require reconsideration as a differentiated type of traumatization (e.g., Horesh, 2015). Considering the growing evidence discerning manmade and non-manmade traumas and their subsequent aftermaths (e.g., Charuvastra & Cloitre, 2008), these too might be justifiably differentiated diagnostically. Moreover, as experts claim, the current PTSD conceptualization fails to adequately address the difference between posttraumatic reactions of victims and those of perpetrators (e.g., Drescher et al., 2011; Litz et al., 2009). These too might warrant diagnostic as well as clinical modifications. Undeniably, any attempt to demarcate PTSD and set its boundaries will inevitably involve some arbitrariness (e.g., Burstow, 2005). Determining which specifications are essential and which are marginal and contingent should direct future research. Surely, a challenge in the diagnostic domain may be the determination of whether symptoms represent comorbidity or a coherent subtype of PTSD (e.g., BPD + PTSD or Depression + PTSD versus CPTSD; e.g., Resick et al., 2012; Sher, 2004). At times such questions may be empirically pursued (e.g., Dekel, Solomon, Horesh, & Ein-Dor, 2014), while in other instances they remain purely interpretative. Nevertheless, we must not shy away from this challenge and face it with all seriousness, keeping in mind the best interest of patients.

4.3. Clinical recommendations

A survey among psychologists, clinicians as well as researchers of various orientations has shown that many find the diagnostic system offered by the DSM limited and insufficient, yet are likely to continue using it for various pragmatic (e.g., diagnostic) reasons (Raskin & Gayle, 2015). In part, such dissatisfaction may be attributed to the abstraction of diagnostic classifications and criteria, and their decontextualized nature. Indeed, the most commonly identified disadvantage of the diagnostic manual, highlighted by more than 60% of the participants in Raskin and Gayle's (2015) study, was that the manual "obscures individual differences." Truly, clinical practice may benefit from much more flexibility and tailoring than diagnostic nosological systems can afford.

A key question is whether having a DSM-5 diagnosis of PTSD allows clinicians to match a treatment to a specific client. Are all forms of PTSD treatable through evidence-based treatments for PTSD (e.g., prolonged exposure)? The "one-size-fits-all" approach for trauma treatment has been challenged in the past, highlighting its relevance for different cultures (Nicolas, Wheatley, & Guillaume, 2014) as well as for different patient populations (Cloitre, 2015). As far as CPTSD is concerned, clinical recommendations already exist, adding aspects of affect regulation and a reestablishment of relational capacities to extant exposure therapy (e.g., Cloitre et al., 2011). Thus, clinicians who acknowledge CPTSD as a syndrome – PTSD symptomatology and affect disturbances included – treat it as a holistic posttraumatic gestalt precipitated, and indeed set into play, by one's complex traumatic past. On the other hand, in cases of OTSR, for instance, wherein the stressful event is ongoing, and therefore renders exposure therapy clinically inappropriate, exposure may be substituted with fear management techniques devised in order to negotiate optimal alertness levels (i.e., not too low and not too high), and maximize patients' ability to function (Diamond et al., 2010; Eagle & Kaminer, 2013). Finally, in the case of cumulative trauma across a life time (Kira et al., 2013), the third exemplar above, it stands to reason that each of the accumulated traumas may be addressed in its unique contribution to the resulting sequelae, but also that the gestalt formed by their cumulative nature be taken into consideration and gradually addressed. In this respect, it makes sense to identify those subtypes for which traditional PTSD treatment would be contraindicative. Generally, as research identifies empirically defensible subtypes of PTSD associated with the qualitative diversity of the precipitating traumatic events, implications concerning this diversity must be considered in relation to the symptomatic clinical picture, so as to enable necessary treatment adjustments.

5. Conclusion and future directions

In her response to Resick et al.'s (2012) critical review of CPTSD, Marianne Goodman (2012, p. 255) concluded that taking into account the "duration of the traumatic exposure, the developmental phase during which it occurred," as well as "the specifics of the traumatic antecedent, could very well help stratify patients according to prognosis and inform treatment selection and the development of new approaches." Concurring with Goodman, we argued in the current paper that there is much refining that must take place if we are to adequately address the whole gamut of posttraumatic reactions, pathological and pseudo-pathological. A major point in this respect is that accepting the centrality of the trauma-reaction relation for diagnosis mandates that variations in potentially traumatic events inflect symptom manifestation and possibly the emerging diagnosis as a whole. Put otherwise, when aiming for a more precise understanding of posttraumatic reactions and their potential trajectories, it is imperative to take into consideration that which has triggered the reaction in the first place.

The current paper is a call for researchers to seek the necessary equilibrium between a unified, undifferentiated PTSD construct and the many variated manifestations of posttraumatic reactions. This may only be done by exploring the recurring relationships between various traumatic experiences and their corresponding aftermaths, and subsequently creating a sub-typical diagnostic system to address these variations. For instance, considering the diversity and richness of PTSD symptomatology, as noted above, there may be hundreds of thousands of different PTSD symptom configurations and permutations, and over 3000 configurations warranting the full diagnosis (Galatzer-Levy & Bryant, 2013). Nevertheless, although research has indicated that different events lead to different PTSD prevalences (e.g., Kessler et al., 1995), the salience of different symptom combinations (Graham et al., 2016), and possibly different comorbidities (Smith et al., 2016), research has barely begun investigating whether specific traumatic events lead to more specified and qualitatively different symptoms and symptom constellations and patterns (e.g., Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009; Pietrzak et al., 2014; Wang et al., 2011). The time is ripe for such an investigation to take place. Moreover, symptoms transcending the current classical PTSD criteria should likewise be considered in such an examination. Invariably, each case of trauma has unique characteristics as well as properties common with other instances. The challenge is that of negotiating the idiographic and the nomothetic, and reaching an adequate nosology or taxonomy that minimizes and counteracts the disadvantages of these antipodal extremities. In sum, what the field of trauma research so desperately needs, as Galatzer-Levy and Bryant (2013, p. 660) note, are "new approaches that examine the heterogeneity in stress response behavior rather than ignoring it."

Bringing this paper to its logical conclusion, we contend that as far as PTSD is concerned, it would seem that one size does not fit all, and most likely, neither would multiple sizes. Nevertheless, we argue that the latter may fit more cases, and do so in a more clinically tailored fashion. As trauma and stress related disorders seem to remain "diagnoses in the making" (e.g., Maercker et al., 2013), the considerations delineated above may be imperative for all who are involved.

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