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REVIEW ARTICLE

The PTSD Criterion A debate: A brief history, current status, and recommendations for moving forward

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Abstract

Posttraumatic stress disorder (PTSD) Criterion A, also known as the "stressor criterion," has been a major source of debate ever since PTSD was added to the third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM*) in 1980. Since then, the traumatic stress field has held an ongoing debate about how to best define Criterion A and the events that it covers. Because of the COVID-19 pandemic and recent race-based incidents, the Criterion A debate has been reinvigorated. In this paper, we review briefly the history of Criterion A and changes in its language across different editions of the *DSM*. We then describe the four main positions held by scholars involved in the Criterion A debate and carefully examine the support for those positions. We conclude by offering recommendations for moving forward.

Since the spring of 2020, the COVID-19 pandemic and increased visibility of the murders of people of color at the hands of police have impacted individuals, institutions, and society. The psychological consequences of these events have been discussed in the news media and become topics of investigation in the scientific literature. Although several studies have reported elevated rates of posttraumatic stress disorder (PTSD) following COVID-19 exposure and racism-related stressors, they have varied considerably in how rigorously PTSD symptoms and diagnostic criteria—particularly Criterion A—have been assessed (e.g., structured diagnostic interview vs. self-report questionnaire), and most did not determine whether COVID-19 and racism-related stressors met the definition of a traumatic event according to the PTSD criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022). Despite the limitations of the research, these events have reinvigorated a longstanding debate in the field about which human experiences should be considered "traumatic."

In this paper, we address this topic, first by reviewing how the definition of Criterion A, known as the "stressor criterion," has evolved since PTSD was introduced in the third edition of the *DSM* (*DSM-III*) in 1980 and how it is defined presently. We then describe the four positions that PTSD scholars have taken within the ongoing debate, namely (a) expanding Criterion A such that more events qualify, (b) narrowing Criterion A such that fewer events qualify, (c) eliminating Criterion A completely, or (d) leaving Criterion A in its present form. We follow this with an evaluation of the evidence for these positions, discuss important considerations for the Criterion A debate, and offer some recommendations for moving forward.

TABLE 1 Posttraumatic stress disorder (PTSD) Criterion A definitions, by Diagnostic and Statistical Manual of Mental Disorders (DSM) edition

DSM edition	Criterion A definition
DSM-III (1980)[a]	The existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.
DSM-III-R (1987)[b]	The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone (e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence).
DSM-IV (1994)[c]	The person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
DSM-5 (2013)[d]	The person was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in one or more of the following ways: 1. Experiencing the event(s) him/herself. 2. Witnessing the event(s) as they occurred to others. 3. Learning that the event(s) occurred to a close relative or close friend. 4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

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A brief history of PTSD Criterion A

Since its introduction in the *DSM-III* (APA, 1980), Criterion A has been both the foundation and most controversial aspect of the PTSD diagnosis (Friedman, Resick, Bryant, & Brewin, 2011; Weathers & Keane, 2007). McNally (2009) argued that the memory of the trauma is the "'heart of the diagnosis and the organizing core around which all other PTSD symptoms can be understood (p. 599)." As for controversy, the major debate since 1980 remains where to draw the line between which experiences are considered traumatic and which experiences are not.

Table 1 shows how Criterion A has changed over time in the *DSM* as part of the ongoing effort to best characterize an event involving direct or indirect exposure to actual or threatened death, serious injury, or sexual violence (See Friedman, 2013; Friedman et al., 2011; and Weathers & Keane, 2007, for a more extensive discussion). Initially, in the *DSM-III*, Criterion A was defined as the "existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone." The text further specified that it had to entail "a psychologically traumatic event that is generally outside the range of usual human experience" (p. 238). In the revised version of the *DSM-III* (i.e., *DSM-III-R*; APA, 1987), Criterion A explicitly included both of these components and provided specific examples of events that would qualify for Criterion A (see Table 1 for the exact wording). The text included indirect exposure in which an individual learned about a traumatic event that a significant other actually experienced (e.g., "learning about a serious threat or harm to a close friend or relative"; p. 248) and stated that the event was "usually experienced with intense fear, terror, and helplessness (p. 247)".

The *DSM-III and DSM-III-R* definitions were criticized for several reasons, the most significant being the suggestion that trauma exposure is very rare when, in fact, it is not. By the time the fourth edition of the *DSM*

(*DSM-IV*; APA 1994) reframed Criterion A in 1994, there was more than enough epidemiological data showing that traumatic events such as sexual and physical assault, disasters, serious accidents, and war were all too common. Breslau et al. (1991) found that almost 40% of a large U.S. sample reported lifetime exposure to traumatic events. In another large sample of U.S. adults, Norris (1992) found that 69% of participants reported exposure to at least one traumatic event in their lifetimes, and 21% of the sample reported exposure to traumatic stress in the past year. Weathers and Keane (2007) argued convincingly that the *DSM-III* definition of PTSD Criterion A referred more to the catastrophic nature of stressors and not the frequency with which they occur.

The *DSM-IV* revision of Criterion A kept many features from the previous versions but also recognized that individual differences play a significant role in both the appraisal of and response to catastrophic events by dividing Criterion A into objective (Criterion A1) and subjective (Criterion A2) components. Criterion A1 described the exposure ("experienced, witnessed, or was confronted with") and the details of the event ("actual or threatened death or serious injury, or a threat to the physical integrity of self or others"). It also included indirect exposure (e.g., learning that a loved one has been exposed to a traumatic event). Criterion A2 required a peritraumatic response involving "intense fear, helplessness, or horror"; this addition was meant to be a "gatekeeper" that would restrict events that qualified for Criterion A. Although the specific language changed, the elements of both Criterion A1 and Criterion A2 had been included previously in the text of *DSM-III-R*. However, for the first time, Criterion A explicitly included the individual's subjective response to the traumatic stressor.

The *DSM-IV* text provided a more extensive list of examples of traumatic stressors, including "being diagnosed with a life-threatening illness," "developmentally inappropriate sexual experiences without threatened or actual violence or injury," "learning about the sudden, unexpected death of a family member or a close friend," and "learning that one's child has a life-threatening disease" (APA, 1994; p. 424). Although these events were not listed explicitly in prior versions of the *DSM*, each of these events would have fulfilled previous versions of Criterion A. Perhaps the most noteworthy change in the *DSM-IV* was the recognition that some individuals may develop PTSD-like symptoms in response to an event that does not meet Criterion A. The text specifies that the appropriate diagnosis in such cases was either adjustment disorder or anxiety disorder not otherwise specified (NOS).

Criterion A was revised again for *DSM-5* (APA, 2013). Specifically, Criterion A1 became more restrictive to eliminate the possibility of certain experiences, particularly the death of an elderly loved one by natural causes, which was often endorsed under *DSM-IV*; however, the sudden violent or accidental death of an elderly loved one still qualified as a Criterion A event. Direct exposure, witnessing, and indirect exposure to most of the other *DSM-IV* traumatic events outlined in the *DSM-IV* were preserved. In addition, Criterion A was updated to include language about occupational exposure to traumatic events, or the aftermath of such events, by professionals who are not typically endangered themselves (e.g., medical personnel, law enforcement, photojournalists). Criterion A2 was eliminated altogether because there was little evidence that it was serving its gatekeeper function reliably. As a result of these changes, Criterion A in the *DSM-5*, like Criterion A in both *DSM-III* and *DSM-III-R*, is based exclusively on exposure to a catastrophic event without requiring a specific accompanying subjective response (i.e., "intense fear, helplessness, or horror" from *DSM-IV*). Although *DSM-IV* Criterion A2 was eliminated, it bears noting that subjective appraisal of an event as potentially lethal or seriously harmful is inherently part of the definition of a traumatic stressor. In summary, although there has been much attention to, scrutiny of, and evolution regarding PTSD Criterion A over time, the underlying notion of a traumatic event as exposure to a catastrophic event involving actual or threatened death or serious harm to one's self or others has remained relatively consistent.

Although Criterion A in *DSM-5* eliminated the *DSM-IV* subjective response qualification (i.e., Criterion A2), the substantially revised language in the *DSM-5* text revision (*DSM-5-TR*; APA, 2022) does discuss how a subjective response is a crucial component of medical events, such as COVID-19 exposure, that qualify for Criterion A (i.e., "a particular event in treatment that evokes catastrophic feelings of terror, pain, helplessness, or immanent death"; p. 305). With respect to COVID-19 and other potentially lethal infectious diseases, patients with severe respiratory distress who were admitted to intensive care units and either experienced or witnessed near-death encounters with devastating features and robust psychological effects would certainly meet Criterion A under the *DSM-5-TR* criteria. Potential COVID-19–related Criterion A scenarios include extreme fear, panic, and fear of death during a respiratory crisis; overwhelming exposure to severely ill COVID-19 patients as a medical professional, especially without adequate personal protective equipment; or witnessing the severe distress of a loved one with catastrophic (i.e., life-threatening) COVID-19 symptoms (Norrholm et al., 2021).

Racism-related stressors that involve actual or threatened death, serious injury, or sexual violence and are directly experienced, witnessed, or learned about when such events happen to loved ones are, by the *DSM-5-TR*

definition, traumatic stressors and may lead to PTSD and other related difficulties. Incidents of mass violence directed toward specific racial and ethnic groups clearly meet PTSD Criterion A. Other racism-related stressors have included police-involved deaths of people of color. People involved in related events, such as social justice (e.g., Black Lives Matter) demonstrations, during which violence is perpetrated against demonstrators may also qualify. Indirect exposure through social and other media does not currently meet PTSD Criterion A.

The Criterion A debate continues

Despite efforts to refine the definition of Criterion A over the past 40 years, debate and controversy about how to best define Criterion A has not yet been resolved, especially in the wake of the recent aforementioned events (e.g., Gradus & Galea, 2022; Wathelet et al., 2021). Some scholars have criticized Criterion A for being too narrow, whereas others have criticized it for being too broad; still others have criticized it for being too difficult to define unambiguously and because it has not been sufficiently predictive of PTSD status.

In this next section, we describe the four main positions that trauma and PTSD experts have taken in the Criterion A debate: (a) expanding Criterion A such that more events qualify, (b) narrowing Criterion A such that fewer events qualify, (c) eliminating Criterion A completely, and (d) keeping Criterion A unchanged.

Expanding Criterion A

The main evidence that proponents of expanding Criterion A cite to support their position is that individuals can report PTSD-like symptoms in response to events that do not meet the current Criterion A definition, such as divorce, the death of a loved one that was not violent or unexpected, financial struggles, extramarital affairs, and childbirth (Bodkin et al., 2007; Gold et al., 2005; Holmes et al., 2016; Larsen & Pacella, 2016; Olde et al., 2006; Rosen & Lilienfeld, 2008). Several recent studies have assessed the extent to which PTSD-like symptoms are associated with the COVID-19 pandemic, broadly speaking (i.e., not necessarily involving exposure to death or extreme suffering associated specifically with being infected with COVID-19). These studies have found evidence of an association between broad exposure to the pandemic, such as testing positive for the disease, having someone in the home or knowing someone at work who tests positive for COVID-19, and requiring any medical intervention for COVID-19, and PTSD symptoms and/or probable COVID-19–related PTSD (e.g., Karatzias et al., 2020). Similarly, although racism, broadly defined, has been associated with various mental health outcomes, including depression and anxiety (Paradies et al., 2015), some researchers have identified a stronger association between experiencing racism and PTSD symptoms (e.g., Sibrava et al., 2019; Williams et al., 2021). A systematic review by Kirkinis et al. (2021) examined 28 studies with a total of 11,775 racially and ethnically diverse participants and found that 70% of studies found an association between racial discrimination and PTSD symptoms. The review's authors focused on studies that explicitly included a specific measure of racial discrimination that utilized items that did not meet Criterion A, such as being treated unfairly in various domains (e.g., school, work, public places, neighborhoods, institutions); being accused or suspected of wrongdoing; and/or having to take drastic steps like filing a grievance, quitting one's job, or moving one's home to address racism.

Narrowing Criterion A

Proponents (e.g., McNally, 2009; Rosen & Lilienfeld, 2008) of the position that Criterion A should be narrowed have pointed out that past versions of Criterion A (i.e., in *DSM-IV*) permitted both direct and indirect trauma exposure such that a person who only learned about someone else being threatened with harm qualified for Criterion A and was, therefore, eligible for a PTSD diagnosis under this definition assuming other criteria were met. McNally (2009) referred to this lack of differentiation between secondhand exposure (i.e., learning about the victimization of someone else after the fact) and the direct, firsthand experience of being victimized as a "conceptual bracket creep." In this perspective, PTSD Criterion A is overly inclusive, likely leading to the overdiagnosis of PTSD. The *DSM-5* addressed the issue of indirect exposure by restricting individuals who meet Criterion A to those who have learned about potential harm to a family member or close friend who experienced a qualifying Criterion A event or, in the case of death, the cause was sudden, violent, and/or accidental. Still, concerns about Criterion A conceptual bracket creep remain on the grounds that an overly inclusive Criterion A prevents the field from identifying reliable putative biomarkers of PTSD; shifts the focus from the stressor to intrapersonal vulnerabilities, thereby undermining the very rationale for having a separate diagnosis of PTSD in the first place; undercuts the rationale for trauma-focused treatments for PTSD, which are still the most effective for treating the disorder; and pathologizes normal emotional responses to stress and adversity. Such concerns have led to the proposal that Criterion A should exclude all indirect, informational exposures and instead

require the individual to be either the direct recipient of the exposure or a witness who was physically present at the scene at the time that others were exposed (McNally, 2009). Under this proposal, individuals who experience PTSD-like symptoms after hearing news about another person's misfortune would be eligible for another diagnosis but not PTSD.

Eliminating Criterion A

As previously mentioned, the *DSM-IV* definition of a traumatic stressor included both an objective description of events that might qualify (Criterion A1) and the individual's subjective response during the event (Criterion A2). The inclusion of a subjective component in the definition of a traumatic stressor was criticized because research showed it was not sufficiently predictive of PTSD diagnostic status (e.g., Breslau & Kessler, 2001; Schnurr et al., 2002) and because it included only fear, helplessness, and horror and excluded other common peritraumatic reactions, such as dissociation, disgust, and anger (e.g., Brewin et al., 2000; Brunet et al., 2001; Roemer et al., 1998; Weathers & Keane, 2007). These criticisms led to the elimination of Criterion A2 in the *DSM-5*. Brewin et al. (2009) called for the complete elimination of Criterion A on the grounds that it is challenging to offer a definition of Criterion A that eliminates all ambiguity about what events qualify as a traumatic stressor and, like Criterion A2, is not sufficiently predictive of PTSD diagnostic status. Like other scholars (Maier, 2006), Brewin et al. (2009) instead suggested that the PTSD diagnostic criteria should consist exclusively of a set of core symptoms because the full PTSD syndrome would be unlikely to occur in the absence of an event that could reasonably be described as traumatic.

More recently, Gradus and Galea (2022) questioned the extent to which the *DSM-5* definition of Criterion A can adequately cover the range of experiences that increase the risk for PTSD and other mental disorders and, like Brewin et al. (2009), questioned the *DSM*'s ability to provide an unambiguous definition of Criterion A. Gradus and Gales (2022) suggested that the *DSM-5*'s lack of an exhaustive list of specific events that qualify for Criterion A indicates that it may not be possible to formulate a complete definition of Criterion A and questioned whether it was even necessary to define trauma at all.

Keeping Criterion A unchanged

Individuals who take the position that Criterion A should remain unchanged contend that there is no clear evidence yet that the current Criterion A definition is problematic and that only when such evidence is uncovered should it be changed accordingly. Advocates of keeping Criterion A unchanged note that studies used to the positions of either expanding, narrowing, or eliminating Criterion A have significant methodological limitations. For example, nearly all these studies, including those focused on the COVID-19 pandemic and racism-based stressors, have relied upon responses to questionnaires or survey instruments to assess PTSD symptoms. Most of these studies have also used cross-sectional study designs that provide no information about the temporal association between stressor exposure and symptom onset. Further, by and large, these studies have not conducted a thorough assessment of participants' trauma histories, properly determined which event or events should serve as the index event for self-reported symptoms, or determined if the reported symptoms were trauma-related. Consequently, many participants' responses in these studies likely reflect nonspecific and possibly nonclinical levels of distress.

In the case of expanding Criterion A, the argument that any event associated with PTSD-like symptoms should be considered traumatic because it is associated with these symptoms is circular reasoning (i.e., the event both causes symptoms and is defined by those same symptoms) and, therefore, problematic from both logical and explanatory perspectives. Relying only on the presence of PTSD-like symptoms to determine what constitutes a traumatic stressor is also problematic because it fails to recognize that most individuals do not develop PTSD following exposure to a Criterion A event (e.g., Goldstein et al., 2016)—in other words, the presence or absence of PTSD-like symptoms following an event cannot define the traumatic nature of the event. Additionally, this approach does not recognize that many PTSD symptoms are not unique to PTSD and overlap significantly with other psychiatric conditions.

In the case of narrowing Criterion A, some scholars have suggested that concerns about bracket creep are exaggerated (e.g., Kilpatrick et al., 1998; Weathers & Keane, 2007). Excluding all indirect, informational exposures from qualifying for Criterion A, in the absence of strong empirical evidence to do so, may be overly restrictive such that individuals who rightfully deserve to be diagnosed with PTSD would not qualify.

In the case of eliminating Criterion A altogether, before the publication of *DSM-5*, the PTSD Work Group decided it would be in the best interest to retain Criterion A in modified form after carefully considering its removal from the PTSD diagnostic criteria (Friedman et al., 2011). The Work Group's justifications for retaining Criterion A included, as previously mentioned, the finding that PTSD typically follows exposure to events that meet Criterion A as currently defined and the understanding that eliminating Criterion A undermines the rationale for a PTSD diagno-

sis, as many of its symptoms overlap with other disorders. Brewin et al.'s (2009) argument that Criterion A should be eliminated because no one would have PTSD unless there was an event that meets Criterion A would only apply if the assessment of PTSD symptoms was conducted by a trained expert using a well-validated structured diagnostic interview; unfortunately, most of the studies on which Brewin et al. based their argument collected data using self-rating scales.

Gradus and Galea (2022) argued that it is unnecessary to require the presumed etiology of PTSD symptoms as part of the PTSD diagnostic criteria because other conditions (e.g., broken bones) do not require the identification of the mechanism through which the condition occurs. Yet, PTSD is not unique in the *DSM-5-TR* in requiring an etiology. The Trauma- and Stressor-Related Disorders category, of which PTSD is a part, includes numerous diagnoses that specify an etiology through which symptoms arise. The neurocognitive disorders category also includes many conditions that specify an etiology (e.g., major or mild neurocognitive disorder due to Alzheimer's disease, traumatic brain injury, HIV infection, Parkinson's disease). The *DSM-5-TR* includes many other diagnoses with onsets caused by an event (e.g., depression or anxiety due to physical illness or pain). Not only does the *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; *ICD-11*; World Health Organization [WHO], 2019), similarly include mental and neurocognitive disorders that require a specified etiology, it also includes two other categories of conditions that do so: (a) injury, poisoning, or certain other consequences of external causes and (b) external causes of morbidity and mortality. For both categories, the WHO defines an injury as being "caused by acute exposure to physical agents such as mechanical energy, heat, electricity, chemicals, and ionizing radiation interacting with the body in amounts or at rates that exceed the threshold of human tolerance" (WHO, 2019). Notably, the *ICD-11* definition of an injury implies exposure to the same types of traumatic stressors that are included in *DSM* PTSD Criterion A (i.e., events involving life threat or serious injury to self or others), and it is likely that many individuals who experience such exposure types would meet all the diagnostic criteria for PTSD (i.e., the psychiatric analog to the physical injuries). Like the *DSM-5* criteria for PTSD and other trauma- and stressor-related disorders, the *ICD-11* does not provide an exhaustive list of the external causes of such injuries.

At the heart of the Criterion A debate is whether traumatic stressors are different in kind from nontraumatic stressors and whether traumatic stressors are different in degree. Stressors that are different in kind are those that are recognized as being qualitatively different from one another. The PTSD field currently distinguishes between traumatic and nontraumatic stressors based on the involvement of direct or indirect exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Any stressor that falls within those specific boundaries is considered traumatic (Criterion A), whereas stressors that fall outside those boundaries are considered nontraumatic. Nontraumatic stressors may present serious coping and resource challenges among individuals who experience them. However, unless these events explicitly involve an immediate threat to one's life or safety, they are not considered traumatic under the current nomenclature even if they are associated with PTSD-like symptoms.

Stressors that are different in degree are those that are of the same kind (e.g., they all qualify as traumatic under the current Criterion A definition) but vary in intensity or magnitude. For example, sexual assault can vary in the degree of force used by the perpetrator or the degree of nonconsensual touching that occurs. Motor vehicle accidents and natural disasters can vary in the degree of physical injury and property damage among involved individuals. Combat exposure can vary in the degree of exposure to threatened or actual death and serious injury to one's self and others. Illness-related (e.g., COVID-19) exposures can vary in the degree to which an individual experiences distress, requires medical intervention, and is exposed to illness-related death. The current Criterion A definition acknowledges differences in degree among stressors that could fulfill Criterion A (i.e., direct vs. indirect exposure, self vs. other exposure, actual vs. threatened exposure, serious injury vs. death), although it remains unclear if this approach is the most clinically useful.

Expanding or narrowing Criterion A would similarly need to explicate clear differences between traumatic and nontraumatic stressors as well as differences in degree (i.e., magnitude or intensity) among stressors considered to be traumatic. Yet, to date, calls to both expand or narrow Criterion A fall short of these requirements. Specifically, calls to expand Criterion A, which have been largely based on the reasoning that any event associated with PTSD-like symptoms should be considered traumatic, have neither provided any explication of how a newly expanded Criterion A distinguishes between traumatic and nontraumatic stressors nor described how stressors that qualify for Criterion A may differ from one another in magnitude. Narrowing Criterion A may reduce criterion bracket creep and clarify the difference between traumatic and nontraumatic stressors. However, that approach provides no guidance on how traumatic stressors may differ in degree from one another. Understandably, scholars

who have advocated for the elimination of Criterion A altogether have offered no suggested direction on how traumatic and nontraumatic stressors may differ from each other or how traumatic stressors may differ in degree.

Recommendations to the field for resolving the Criterion A debate

The controversy surrounding PTSD Criterion A is far from over. In the service of resolving the debate once and for all, we offer the field several recommendations.

Recommendation 1: Address specific questions about Criterion A through research

The traumatic stress field must conduct additional research to answer lingering questions about Criterion A. One question to consider in future research efforts is whether a revised Criterion A, either expanded or narrowed, might improve understanding of the mechanisms involved in the development of PTSD; the ability to predict who develops, and recovers from, PTSD and the course of PTSD symptoms in the wake of traumatic stress exposure; and the ability to successfully treat individuals with PTSD. Related questions include: (a) What is the best way to characterize the range of significant distress reactions to stressors?; (b) What is the best way to characterize the range of stressful experiences that result in significant clinical distress?; (c) What are the genetic, epigenetic, molecular, neural circuitry, physiological, behavioral, and self-report correlates of the spectrum of adverse experiences, and are there intrinsic differences in these correlates among stressors that do and do not qualify for Criterion A status?; and (d) What is the best way to describe and quantify the differences in magnitude among stressors that do qualify for Criterion A?

Given the recent events of the pandemic and racism-related stressors, additional research should examine whether vicarious exposure through the media or other means (e.g., hearing the gruesome details of an experience that happened to someone else) should qualify as Criterion A stressors. Based on findings from prior research showing that individuals can develop PTSD symptoms when they are repeatedly exposed to bodily remains and other grotesque consequences of traumatic events during the course of their assigned professional or occupational duties (see Friedman et al., 2011), the *DSM-5* PTSD Workgroup decided that exposure to those events through electronic media would only meet Criterion A if that exposure was part of an individual's repetitive professional responsibilities, such as among military mortuary workers, first responders, law enforcement officials, journalists, and mental health care providers. At the time that the PTSD Workgroup was deliberating, the few available studies regarding nonprofessionals showed a low likelihood of PTSD associated with electronic media exposure to adverse events among civilians (e.g., media exposure related to the September 11, 2001, terrorist attacks; Neria & Sullivan, 2011). However, it is reasonable to revisit this question given the much larger and evolved role that electronic media plays in daily life today compared with 2013. For example, is repeated exposure depicting the murder of individuals of color at the hands of law enforcement a Criterion A stressor among individuals of color? This and similar questions should be a focus of research going forward. Additionally, research on vicarious exposure should consider the possibility that these exposures may trigger recollections of prior experiences that more clearly meet the current Criterion A definition and not be the source of presenting symptoms per se.

One possible way to move toward scientific consensus on how to best define Criterion A would be to conduct a comprehensive, population-representative taxometric study of adverse life events. Previously, Dohrenwend (2000, 2010) proposed six general characteristics of stressful life events: (a) source (i.e., factors that cause the occurrence of stressful events that are external and beyond the control of the individual), (b) valence (i.e., events characterized by a loss vs. events characterized by a gain), (c) unpredictability of the event, (d) magnitude (i.e., the extent to which the event is likely to bring about significant negative changes in one's life), (e) centrality (i.e., how much the adverse event interferes with the achievement or maintenance of an important personal goal), and (f) the likelihood that the event overwhelms and impairs one's physical capacity to cope with the event. In this framework, life events that are characterized by the highest levels of uncontrollability, loss, unpredictability, life changes, threat to goals, and incapacity to cope would be those that are likely to be considered traumatic. Regarding pandemic- and racism-related stressors, Dohrenwend's last proposed characteristic, which encompasses being physically exhausted to the point of not having adequate capacity to cope with the life stressor, may be the most pivotal—and psychobiologically critical—in determining whether an event meets the threshold for Criterion A.

Using Dohrenwend's (2000, 2010) proposed dimensions to study life events with a population-representative sample would provide a more detailed understanding of how stressful life events impact people's lives. A

population-representative sample would allow stratification based on characteristics such as age, gender identity, sexual orientation, race, ethnicity, educational attainment, and socioeconomic status. Doing so would allow for an examination of the phenomenology of adverse life experiences through the larger social context in which it exists. In that model, a set of intersecting circles, indicating which traumatic stressors overlap across population subgroups and which are unique for each population subgroup, could be constructed. Accompanying work clarifying the biomarker, psychological process, psychiatric comorbidity, and functioning correlates of the spectrum of adverse experiences would further help to clarify the nature and definition of traumatic stress.

Of course, any such study of the boundaries of Criterion A should include a careful and thorough assessment of lifetime stressor exposure and associated PTSD symptomatology conducted using the most rigorous means possible (i.e., diagnostic interviews administered by trained assessors; Marx et al., 2021). An overreliance on self-rating instrumentation and cross-sectional study designs to examine the nature of Criterion A and its associations with related symptoms has been and continues to be a major problem for the field.

Recommendation 2: Preserve Criterion A in its current form until questions are sufficiently answered

As discussed, PTSD is not a unique case among disorders in that it both defines and requires identification of the external cause of symptoms. The inclusion of the external cause of PTSD symptoms may have important implications for understanding symptom course and progression, determining legal responsibility for symptom-related disability, and informing intervention efforts. Thus, until replicable scientific observations of phenomena refute the current PTSD diagnostic paradigm, we strongly recommend retaining Criterion A in the PTSD diagnostic criteria in its current form.

Even with additional research on the nature of traumatic stress, we acknowledge that there will always be life events that are difficult to categorize as either traumatic or nontraumatic (e.g., having a case of COVID-19 that requires some type of lower-level medical intervention but does not involve a respiratory crisis or admission to an intensive care unit, a Black person being pulled over for a routine traffic stop). Given their own histories and experiences, as well as those of others, individuals in such instances may experience a legitimate fear for their safety and well-being even though there is no explicit threat of death or serious injury. At the same time, it is prudent to exercise caution in permitting an appraisal of danger in the absence of imminent, proximal, and tangible threat of harm to qualify as a Criterion A stressor. Worrying about catastrophic events happening (e.g., worrying about one's self or others dying from a COVID-19 infection, worrying about being assaulted) is not the same as actual exposure to these events. Equating the two blurs the line between reality and fear in a way that is unhelpful for understanding the effects of trauma exposure.

Understanding how an individual has experienced a stressor is necessary for determining whether the stressor meets the definition of Criterion A. In their review of the literature, Bovin and Marx (2011) concluded that a traumatic stressor should be defined by the interaction between the individual and their environment. The authors noted that using only the characteristics of the event to define it as traumatic is problematic because doing so overlooks the reality that not everyone has the same response to the same life stressor. Similarly, solely relying on an individual's response to define an event as traumatic is challenging because it ignores the fact that most people exposed to Criterion A events do not develop PTSD and that there are other clinically significant posttraumatic reactions besides PTSD (e.g., depression, substance abuse). There are important individual differences in both coping capacity and the threshold for appraising an adverse event as a traumatic threat. This perspective was echoed recently by Gradus and Galea (2023), who noted that the context in which events occur may be important in determining their traumatic nature. In some cases, misperceiving or catastrophizing an ambiguous or nonharmful event as potentially harmful can result in appraising such an event as traumatic. If there is a previous history of a traumatic encounter that resembles the index event in important ways, a nontraumatic index event may trigger the reexperiencing of a bona fide Criterion A experience. However, it is important to recognize that if PTSD occurs, the previous event met Criterion A, whereas the index event is a traumatic reminder. It is how an individual initially perceives or responds to a nontraumatic, non–life-threatening stressor that can result in appraising this experience as a traumatic, life-threatening event. In these instances (e.g., a routine traffic stop that goes terribly wrong), it is important to recognize that the individual's initial response is not necessarily pathological in and of itself (Carter, 2007); rather, it may be a reasonable response as a function of other external factors and/or experiences (e.g., racism). In so doing, these other experiences, although not necessarily traumatic themselves, may increase the risk for the development of PTSD in response to previous events that meet Criterion A.

Recommendation 3: Use other diagnostic options for exposures that do not meet PTSD Criterion A

When an event does not meet Criterion A, there are other diagnostic options with which clinicians and researchers can document the impact of these adverse experiences and treat patients with the symptoms associated with such events, namely (a) adjustment disorder and (b) other specified trauma- and stressor-related disorder. Unfortunately, there is very little research on effective treatments for either disorder, and these disorders include a wide variety of nonspecific symptoms that may or may not include symptoms of PTSD. More research on these other diagnostic options would be helpful to the field. This is especially important as there may be an understandable reluctance to use the same nonspecific diagnoses for a clinically meaningful response to the chronic stress of structural or cultural racism or a distressing, debilitating, and humiliating racist encounter as would be used for an acrimonious divorce or business setback. This diagnostic conundrum is not unique to racist events or medical conditions that do not involve imminent life threat but may also be seen in other contexts, such as among veterans exposed to non–Criterion A war zone experiences, individuals who encounter workplace sexual harassment, or elderly or disabled individuals facing discrimination. In addition, Criterion A events that cause severe clinically significant distress but do not result in a person meeting other PTSD diagnostic criteria also would require a diagnosis of adjustment disorder or other specified trauma- and stressor-related disorder. A detailed discussion of the possible need for a unique diagnosis for racism-related stressors as others have suggested (Bryant-Davis & Ocampo, 2005; Carter, 2007; Holmes et al., 2016; Spanierman & Poteat, 2005), is beyond the scope of this paper, but it is a relevant and very important question to consider.

CONCLUSIONS

Ever since the inclusion of PTSD in the *DSM*, there has been considerable discussion about how to best define traumatic stress, which experiences qualify as traumatic stressors, and how to best operationalize the definition of traumatic stress for diagnostic purposes. Recent events around the globe have reenergized these discussions, with some scholars asserting there is a need to revisit and revise the current definition. Given the lack of a clear direction for change at this time, we recommend maintaining the current definition of Criterion A. To support any change to Criterion A, research that addresses the aforementioned questions and challenges that remain with respect to arriving at a definition of a traumatic stressor that satisfies all invested parties (i.e., affected individuals, clinicians, researchers, and policymakers) must be conducted. This work will require resources from funding agencies to invest in advancing knowledge of the concept of traumatic stress. Although conceptual disagreements regarding Criterion A persist, we are certain that the entire PTSD field is unified on one singular goal: validating patients' emotionally painful experiences regardless of whether they meet the current *DSM-5* PTSD Criterion A and facilitating appropriate understanding and clinical care.

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