

The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category

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A central assumption behind psychiatric diagnoses is that a disease has an objective existence in the world, whether discovered or not, and exists independently of the gaze of psychiatrists or anyone else. In other words, neolithic people had post-traumatic stress disorder as have people in all epochs since. However, the story of post-traumatic stress disorder is a telling example of the role of society and politics in the process of invention rather than discovery.

The diagnosis is a legacy of the American war in Vietnam and is a product of the post-war fortunes of the conscripted men who served there. They came home to find that they were being blamed for the war. Epithets like “babykiller” and “psychopath” were thrown at them by some who had watched on television the US military’s atrocities against defenceless peasants. This reception was a primary factor in the well publicised difficulties—such as antisocial behaviour—that some military personnel had in readjusting to their peacetime roles. Those who were seen by psychiatrists were diagnosed as having an anxiety state, depression, substance misuse, personality disorder, or schizophrenia; these diagnoses were later supplanted by post-traumatic stress disorder.

Early proponents of the diagnosis of post-traumatic stress disorder were part of the antiwar movement in the United States; they were angry that military psychiatry was being used to serve the interests of the military rather than those of the soldier-patients. The proponents lobbied hard for veterans to receive specialised medical care under the new diagnosis, which became the successor to the older diagnoses of battle fatigue and war neurosis. The new diagnosis was meant to shift the focus of attention from the details of a soldier’s background and psyche to the fundamentally traumatic nature of war. This was a powerful and essentially political transformation: Vietnam veterans were to be seen not as perpetrators or offenders but as people traumatised by roles thrust on them by the US military. Post-traumatic stress disorder legitimised their “victimhood,” gave them moral exculpation, and guaranteed them a disability pension because the diagnosis could be attested to by a doctor; this was a potent combination. (In both South Africa and Bosnia men accused of politically inspired multiple murders have used post-traumatic stress disorder as a defence.)

At no time was the debate in the psychiatric community in the US about whether or how diseases

Summary points

A psychiatric diagnosis is not necessarily a disease

Distress or suffering is not psychopathology

Post-traumatic stress disorder is an entity constructed as much from sociopolitical ideas as from psychiatric ones

The increase in the diagnosis of post-traumatic stress disorder in society is linked to changes in the relation between individual “personhood” and modern life

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or disorders exist, merely whether there was one that had yet to be discovered. As Scott wrote:

In the story of [post-traumatic stress disorder] we see again how the orderliness of the natural world is to be found in the very accounts of its orderliness. Theories represent competing sets of assumptions that are inseparable from the interpretation of the evidence taken to support them and their predictions. Hence scientists and those who adopt its discourse evaluate evidence and make claims about what they have discovered. The goal is to move disputed claims along a path towards acceptance as taken-for-granted fact. This calls for appropriate documentation, the ability to command the attention and respect of critical persons and groups, and the skills and resources necessary to marshal this effort. This is how facts are made.²¹

The growth in popularity of the diagnosis

Despite the atypical nature of the experiences of American veterans in Vietnam, the diagnosis of post-traumatic stress disorder has become almost totemic. The National Center for Post-Traumatic Stress Disorder in the United States tracks journal articles, books, technical reports, doctoral dissertations, etc, that are written on the subject. Although coverage is largely limited to publications in English, and even then is only partial, more than 16 000 publications had been indexed by September 1999. One striking development, although not the subject of this paper, has been the global spread of the use of this diagnosis by humanitarian programmes. It is promoted as a basis for capturing and addressing the impact of events like wars regardless of the background culture, current situation, and subjective meaning brought to the

experience by survivors. Thus the misery and horror of war is reduced to a technical issue tailored to Western approaches to mental health. This has been criticised elsewhere.^{2 3}

In Western societies the conflation of distress with “trauma” increasingly has a naturalistic feel; it has become part of everyday descriptions of life’s vicissitudes. The profile of post-traumatic stress disorder has risen spectacularly, and it has become the means by which people seek victim status—and its associated moral high ground—in pursuit of recognition and compensation. An editorial in the *American Journal of Psychiatry* commented that it was rare to find a psychiatric diagnosis that anyone liked to have but post-traumatic stress disorder was one.⁴

Originally framed as applying only to extreme experiences that people would not expect to encounter every day, it has come to be associated with a growing list of relatively commonplace events: accidents, muggings, a difficult labour (with healthy baby), verbal sexual harassment, or the shock of receiving (inaccurate) bad news from a doctor even in cases in which the incorrect diagnosis has been rescinded shortly afterwards. Increasingly the workplace in Britain is being portrayed as traumatogenic even for those who are just doing their jobs: paramedics attending road accidents, police constables on duty at disasters, and even employees caught up in what would once have been described as a straightforward dispute with management. All are seeking compensation for post-traumatic stress disorder or for not being offered counselling. A recent paper described a postal questionnaire survey of doctors involved in treating the survivors of the Omagh bombing in 1998.⁵ The authors concluded that 25% of the sample had post-traumatic stress disorder and were critical of them for not seeking treatment. There are real implications for society and indeed for the NHS in these trends.

Post-traumatic stress disorder, concepts of “personhood,” and modern life

The constructs of “psychology” or “mental health” are social products. Collectively held beliefs about particular negative experiences are not just potent influences but carry an element of self fulfilling prophecy; individuals will largely organise what they feel, say, do, and expect to fit prevailing expectations and categories. Underpinning these constructs is the concept of “person” that is held by a particular culture at particular point in time. This embodies questions such as how much or what kind of adversity a person can face and still be “normal”; what is reasonable risk; when fatalism is appropriate and when a sense of grievance is; what is acceptable behaviour at a time of crisis including how distress should be expressed, how help should be sought, and whether restitution should be made. In Britain, for example, personhood has traditionally invoked notions of stoicism and understatement—the “stiff upper lip”—and of fortitude (exemplified by the “bulldog” tenacity which popular memory holds as a characteristically British response to a crisis like the threat of Hitler).

There is a tension between these older, time honoured constructions, which centre on resilience and composure, and what is emerging today. When a psychiatrist or psychologist attests that an unpleasant but scarcely extraordinary experience has caused

objective damage to a psyche with effects that may be long lasting, a rather different version of personhood is being posited.

This may be understood in terms of cultural and socioeconomic shifts. Today an expressive, psychologically minded individualism is increasingly common. On the one hand the modernisation of society has seen a loss of the binding properties of its fabric and on the other there has been a promotion of personal rights and the language of entitlement. A nation is judged as if it is primarily an economy rather than a society, and the lexicon of commerce increasingly regulates social relationships and responsibilities (not least in respect of health). The gap between winners and losers grows wider. Moreover, belief in the comfort of religion and in the benevolence of authority is waning. An individualistic, rights conscious culture can foster a sense of personal injury and grievance and thus a need for restitution in encounters in daily life that were formerly appraised more dispassionately. Post-traumatic stress disorder is the diagnosis for an age of disenchantment.

Today there is often more social utility attached to expressions of victimhood than to “survivorhood”; this is perhaps the reverse of 50 years ago. (In contrast in the former Soviet Union there was no social utility in victimhood: state dogma emphasised endurance and stoicism, and victims were advised to keep silent. There was little basis for a discourse on “trauma.”⁶)

Once it becomes advantageous to frame distress as a psychiatric condition people will choose to present themselves as medicalised victims rather than as feisty survivors. In western societies, people can receive compensation for psychic discomfort in some contexts although not in others. They cannot receive compensation for the psychic discomfort of unemployment or poverty or imprisonment: the criteria for these are societal not medical. Although the basis of many compensation cases for post-traumatic stress disorder is moral—that is, embracing the sense of having been wronged—rather than psychological, the psychiatric category is the instrument by which a moral charge is fashioned into a medicolegal one. In the West positivism and instrumental reasoning (that is, reasoning based on supposed empirical proof) are privileged modes of persuasion: to show that you have been wronged you seek to show that you were not just hurt but impaired. The diagnosis of post-traumatic stress disorder is the certificate of impairment.

There is a veritable trauma industry comprising experts, lawyers, claimants, and other interested parties; it is a kind of social movement trading on the authority of medical pronouncements. An encounter between a sympathetic psychiatrist and a claimant is primed to produce a report of post-traumatic stress disorder if that is what the lawyer says the rules require and what has, in effect, been commissioned. In the United Kingdom awards for psychological damages based on the diagnosis can be several times higher than, say, the £30 000-£40 000 limit that the Criminal Injuries Compensation Authority applies for the traumatic loss of a leg.

Problems with defining post-traumatic stress as a psychiatric disorder

In a study of the genesis of post-traumatic stress disorder, the medical anthropologist Young concluded:

"The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources."⁷ This is a challenge to the disorder's objective status as disease but not to its existence: each time the diagnosis is made, each time a new paper is published, each time a new claim for compensation is made, its apparently free standing existence and natural place in the world is reaffirmed.

The disorder has had a secure place in successive editions of international classification systems like the *Diagnostic and Statistical Manual of Mental Disorders*. A perusal of any edition of the manual shows that post-traumatic stress disorder is not the only non-disease that is shaped as much by social concepts as by psychiatric ones—for example, see antisocial personality disorder. With each new edition some disorders are classified for the first time (where were they before?) and others disappear (where did they go?). This is a reminder that a psychiatric diagnosis is primarily a way of seeing, a style of reasoning, and (in compensation suits or other claims) a means of persuasion: it is not at all times a disease with a life of its own.

The most recent reformulation of post-traumatic stress disorder in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) makes it still easier to qualify for the diagnosis by widening the definition of traumatic stressors to include the experience of hearing the news that something bad has happened to someone to whom one is close: second hand shocks now count. None the less, from a psychiatric point of view the problems with the disorder are unconnected to the nature or degree of the events that supposedly provoked it and would not be resolved by retaining the diagnosis only for undoubtedly extreme experiences. So called traumatic memory, seen by proponents of the diagnosis as the basic pathology of the disorder, is in general no sounder conceptually when attributed to people exposed to an atrocity or catastrophic accident than when attributed to those exposed to the lesser events mentioned above.

Psychiatric assessment of the factors associated with a clinical disorder might commonly include retrospective attribution to biological vulnerability and life experiences. Uniquely, post-traumatic stress disorder operates in the opposite direction: in DSM-IV it is taken for granted that time and causality move from the traumatic event towards the criteria and the event is specifically expressed in the content of the symptoms. This sense of time, and the "traumatic" memory it delivers, is a psychiatric construct rather than a natural entity. Throughout history people have had disturbing recollections and despair, but the idea of traumatic memory as a fixed, circumscribed, pathological entity is recent.⁷

The entire canon of diagnostic categories in DSM-IV is phenomenological and descriptive, bar post-traumatic stress disorder. Aetiology is not included in definitions because it is invariably multifactorial. Only post-traumatic stress disorder supposes a single cause (S Wessely, annual meeting of the Royal College of Psychiatrists, Edinburgh, 3 July 2000). What makes the disorder preferred to other potential diagnoses is the term "post-traumatic" in its name, which seems to



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"prove" a direct aetiological link between the present and an index event in the past that excludes other factors. This is scientifically and clinically dubious. Studies of those exposed to a range of manmade and natural events have consistently found that factors before the event account for more of the variance in symptoms of the disorder than do characteristics of the event. These factors include having the tendency to respond to life experiences with negative emotions (trait neuroticism); believing that one is helpless in the face of events; using an emotion focused coping style ("how am I feeling?") rather than a problem focused coping style ("what do I need to do?"); having a history of psychiatric disorder; and on whether social support is available, whether religious or political commitment is present, and the person's level of intelligence.⁸

The diagnosis is claimed to represent a distinct category of psychopathology, but it is largely grounded in phenomena that are common to many other psychiatric diagnoses, such as mood, anxiety, sleep patterns, etc. What is distinctive about an adverse experience for a survivor would come through in the active conceptualising and meaning making of that experience, a process which the survivor undertakes. However, no psychiatric model captures this.

Above all, the diagnosis of post-traumatic stress disorder lacks specificity: it is imprecise in distinguishing between the physiology of normal distress and the physiology of pathological distress. The criteria in DSM-IV are subjective, and the diagnosis can be made in the absence of significant objective dysfunction. The objectification of distress or suffering means that subjective consciousness is reified; this reification risks being clinically meaningless and a "pseudocondition." There is no more graphic demonstration of this than the results of a community survey of 245 randomly selected adults in war torn Freetown, Sierra Leone, in whom post-traumatic stress disorder was diagnosed in no less than 99%.⁹

Conclusions

This paper has highlighted some of the medical and sociological discussions about post-traumatic stress

disorder and the interplay between them. The psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardised ways and are amenable to technical interventions by experts. But human pain is a slippery thing, if it is a thing at all: how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to a technical matter.

Trauma has become a pervasive idiom of distress in Western culture, and day to day usage—as with related terms like “emotional scarring”—is typically metaphorical. But when does it credibly denote a disease akin to physical trauma? The medical discourse on trauma has had heuristic value and some of those diagnosed as having post-traumatic stress disorder do have clinically significant psychiatric dysfunction, however it is labelled (and post-traumatic stress disorder will sometimes do). However, it might be timely for mental health professionals to review our definition of the disorder as a disease and decide whether it has sufficient robustness and explanatory power to apply to the diverse uses to which it is now being put. Society confers on doctors the power to award disease status and the social advantages attached to the sick role. Current practice, which labels people as being mentally ill when they are not, calls this public duty of doctors into question. To conflate normality and pathology devalues the currency of true illness,

promotes abnormal illness behaviour, and incurs unnecessary public costs.¹⁰

In turn, society might reflect that the medicalisation of life, which has gathered pace in this century, tends to mean that distress is relocated from the social arena to the clinical arena. This is a two edged sword: there are practical gains for some, but costs may accrue for everyone over time if contributing factors rooted in political and commercial philosophies and practices escape proper scrutiny.

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Systematic reviews from astronomy to zoology: myths and misconceptions

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Systematic literature reviews are widely used as an aid to evidence based decision making. For example, reviews of randomised controlled trials are regularly used to answer questions about the effectiveness of healthcare interventions. The high profile of systematic reviews as a cornerstone of evidence based medicine, however, has led to several misconceptions about their purpose and methods. Among these is the belief that systematic reviews are applicable only to randomised controlled trials and that they are incapable of dealing with other forms of evidence, such as from non-randomised studies or qualitative research.

The systematic literature review is a method of locating, appraising, and synthesising evidence. The value of regularly updated systematic reviews in the assessment of effectiveness of healthcare interventions was dramatically illustrated by Antman and colleagues, who showed that review articles failed to mention advances in treatment identified by an updated systematic review.¹

It is nearly a quarter of a century since Gene Glass coined the term “meta-analysis” to refer to the quantitative synthesis of the results of primary studies.² The importance of making explicit efforts to limit bias in the review of literature, however, has been emphasised by social scientists at least since the 1960s.³ In recent

Summary points

The use of systematic reviews is growing outside health care

There are still many common myths about their methods and utility

Some common misconceptions are that systematic reviews can include only randomised controlled trials; that they are of value only for assessing the effectiveness of healthcare interventions; that they must adopt a biomedical model; and that they have to entail some form of statistical synthesis

Systematic reviews have always included a wide range of study designs and study questions, have no preferred “biomedical model,” and have methodologies that are more flexible than is sometimes realised

Many of the common criticisms of systematic reviews are fallacious

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