Usefulness and validity of post-traumatic stress disorder as a psychiatric category

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Post-traumatic stress disorder has attracted controversy and scepticism since its first appearance in the *Diagnostic and Statistical Manual of Mental Disorders* in the 1980s.[1] Over the years the diagnostic criteria have been refined and revised, but the causal relation between the diagnosis and an external trauma has remained fundamentally unchanged. Post-traumatic stress disorder is associated with clinically important distress that transcends ordinary misery and unhappiness as well as with disruption and impairment of daily functioning. We argue that the diagnosis is valid and important for both patients and doctors.

Summary points

- Post-traumatic stress disorder is a valid and useful diagnosis but is not the only psychiatric response to trauma
- Prevalence in the general population is estimated between 1% and 7.8%
- The disorder is associated with high rates of psychiatric comorbidity and impairment in social and occupational functioning
- Post-traumatic stress disorder can be differentiated from other psychiatric diagnoses by biochemical, neuroanatomical, and phenomenological characteristics
- Concerns about the diagnosis in victims of chronic and lifelong trauma could be resolved by further refinement of the diagnostic criteria

Social or psychiatric diagnosis?

One of the main criticisms of the diagnosis of post-traumatic stress disorder is that it has been constructed out of sociopolitical ideas rather than psychiatric ones.[2] However, most psychiatric conditions reflect changes in human thinking over time.[3] For example, changes in the political climate and fashion were more influential than advances in medical research in altering the categorisation of homosexuality as a disease. Social factors such as poverty also contribute to mental illness, stress, suicide, family integration, and substance misuse.[4] Sociocultural factors may determine whether the person is able to cope with the potentially traumatising experiences that set the stage for the development of post-traumatic stress disorder.[5]

What does diagnosis achieve?

The diagnosis of post-traumatic stress disorder was developed partly as an attempt to normalise the psychological, cognitive, and behavioural symptoms observed in many traumatised people. It redefined the symptoms of the disorder as a normal response to an abnormal event rather than a pathological condition. The diagnosis of post-traumatic stress disorder helped to deflect blame away from the sufferer and diminish his or her sense of guilt, shame, and failure. Nevertheless, the disorder is associated with low rates of referral for treatment and high rates of early drop out from treatment.[6]

The main purposes of a diagnostic classification are to facilitate communication between clinicians and researchers, promote research activity, encourage the development of specific treatments, provide information about prognosis, and allow services to be developed.[7] The diagnosis of post-traumatic stress disorder meets these requirements. This contrasts with the diagnosis of personality disorder; not only is this a socially constructed condition, but the classification offers little guidance for treatment or diagnostic validity, and the diagnosis is, by definition, highly stigmatising.[8]

Validity of diagnosis

The fact that the diagnosis of post-traumatic stress disorder has been internationally recognised is an indication of its usefulness and perceived validity. However, awareness is increasing that the diagnosis has more validity for some groups of trauma survivors than others. People who have suffered repeated chronic trauma, including victims of torture, intrafamilial violence, or childhood abuse, tend to present with a more chronic and complex clinical picture.[9] This is more closely embodied by the ICD-10 (international classification of diseases, 10th revision) diagnosis, "enduring personality change after catastrophic experience."[10] Post-traumatic stress disorder is now known to be only one of several possible psychiatric responses to trauma, and it should not be allowed to

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BMJ 2001;323:561–3

trump other equally serious and disabling mental disorders that may arise.[11]

Causes and effects of post-traumatic stress disorder

Although an external traumatic event is the central aetiological factor in the development of post-traumatic stress disorder, pre-existing vulnerability factors are important, particularly after less severe trauma.[12] This is also true for psychiatric illnesses such as schizophrenia and depression, in which vulnerability factors may predispose the individual to develop the illness but do not influence the phenomenology and are not incorporated into the diagnostic criteria.

Epidemiological studies in the United States have found rates of post-traumatic stress disorder between 1% and 7.8%.[13 14] There has been no study on the epidemiology of trauma and post-traumatic stress disorder in the United Kingdom, but comparative data from other developed countries suggest the rates of post-traumatic stress disorder are similar to those in the United States.[15] People who have post-traumatic stress disorder are at increased risk of developing other psychiatric disorders[14] and are at significantly increased risk of committing suicide.[16] The effect of post-traumatic stress disorder on employment and work productivity is similar to that associated with depression and translates into an annual loss of productivity above $3bn (£2.1bn) in the United States.[16] The national comorbidity survey identified increased odds of school and college failure, teenage pregnancy, marital instability, and current unemployment associated with a diagnosis of post-traumatic stress disorder.[14] Thus, the socioeconomic consequences, as well as the personal distress associated with diagnosis, are substantial.

Biochemical and anatomical evidence

Evidence is accumulating that post-traumatic stress disorder is a discrete nosological entity with biochemical, neuroanatomical, and phenomenological characteristics that differentiate it from other major psychiatric disorders. Dysregulation of the hypothalamic-pituitary-adrenal axis in patients with post-traumatic stress disorder results in low urinary cortisol concentrations,[17] raised concentrations of cerebrospinal fluid corticotrophin releasing factor,[18] increased numbers of lymphocyte glucocorticoid receptor sites,[17] and hypersuppression of cortisol with low dose dexamethasone.[19] Recent research on the neurobiology of severe stress has shown a breakdown of the blood-brain barrier, changes in neuronal function, and altered gene expression and abnormal neurotransmitter production.[20]

Neuroanatomical abnormalities affecting the medial prefrontal cortex, hippocampus, and visual association cortex have been identified in patients with post-traumatic stress disorder.[21] These areas of the brain are involved in memory. Neurotransmitters and neuropeptides released during stress may result in overconsolidation of memory traces, giving rise to the intrusive memories of post-traumatic stress disorder.[22] According to recent dual representation theory, vivid re-experiencing and ordinary biographical memories of trauma are represented by separate memory systems[23] so that sensory data, associated with an emotionally important event, is stored in memory without cortical processing.

SUE SHARPLES

Litigation

In spite of this growing body of research supporting post-traumatic stress disorder as a separate and distinct psychiatric diagnosis, there is widespread criticism, not only of the diagnosis, but of the concept of a discrete psychiatric response to trauma. Much of this criticism has been focused on the sometimes indiscriminate use of the diagnosis in civil litigation and the apparent growth of a trauma industry. Post-traumatic stress disorder is the only psychiatric disorder for which compensation can be paid. It thus gives rise to the potential for malingering and the intentional production or exaggeration of psychiatric symptoms and disability. Although in some instances the legal process, and more specifically the promise of financial compensation, may promote and prolong psychiatric symptoms,[24] the potential for secondary gain has been recognised for years in psychiatry, and studies of the effect of compensation on post-traumatic symptoms have been inconclusive.

Summerfield recently argued that in Britain, victims of trauma should resort to the "time honoured constructions" of "stiff upper lip" rather than importing the "blame culture" from the United States.[2] Whether the increasing emotionality of the British people is to be applauded or deplored, depends on your political and philosophical viewpoint. However, the fact that something is not talked about does not mean that it doesn't exist, merely that we are not inconvenienced by having to think about or deal with it. It is only relatively recently, for example, that the extent and effects of domestic violence and childhood abuse have been recognised by health professionals. Before this, the problem was invisible because of the social pressure on women and children to deny their suffering. As with the arguments about psychological trauma, the increasing willingness in society for these issues to be discussed is not in itself responsible for causing the problem. Nor should the fact that many victims require treatment for a range of post-traumatic psychiatric symptoms be interpreted as an attempt by the psychiatric profession to medicalise normal human misery.

Conclusions

Post-traumatic stress disorder is precipitated by events that are distressing and disturbing not only to the person who recounts them but also to the listener. Denial of suffering may be one way of coping with distress and anxiety; accepting psychic trauma as a fact requires acknowledgement of our own vulnerability to trauma and victimisation. However, dismissing post-traumatic stress disorder as a valid diagnosis denies the ongoing suffering of people who have been exposed to severe and life threatening trauma. Although we recognise the current limitations of the diagnosis of post-traumatic stress disorder, especially across cultures and to victims of chronic lifelong trauma, we believe this is merely an argument for further refinement of the diagnosis, underpinned by high quality research. It is not an argument for abandoning the diagnosis altogether.

Competing interests: None declared.

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(Accepted 29 June 2001)

Should NHS patients be allowed to contribute extra money to their care?

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The founders of the NHS were guided by the 1942 Beveridge report and wanted to ensure that "the best that science can do is available for the treatment of every citizen at home and in institutions, irrespective of his personal means."[1] The achievability of this assumption has been questioned ever since. Weale has argued that it is impossible to have universal access to the highest quality of care associated with freedom from cost at the point of need.[2] Widespread access may have to compromise quality. Sikora recently suggested that poor UK cancer survival rates reflect a lack of NHS resources to make available "the best that science can do."[3] He argued in a national newspaper that NHS patients should be allowed to pay for additional treatment.[4]

Summary points

Rationing occurs when markets deny goods to citizens—even when the citizens have the resources to buy goods

Patients wishing to supplement their NHS provision by buying extra treatments bring libertarian and egalitarian values into conflict

The NHS currently proscribes mixed private and public provision of care during a treatment episode, yet such provision does take place

Attitudes are shifting about whether the NHS should allow patients to supplement their care from their own resources

The case

This proposal to allow patients to pay for additional treatment was debated by the Nottingham ethics of clinical practice committee[5] in a case referred by a consultant oncologist. The patient was a man in his late 40s with a brain tumour whose prognosis with conventional treatment was poor. The patient had searched the internet and discovered that a drug marketed specifically for his condition was available and had asked the consultant for it. He was told that the drug was considered to be of marginal benefit, and the hospital could not provide it owing to resource constraints. The patient then asked whether he could buy it. Although willing to administer the drug without charging the patient for his services, the consultant was advised by hospital management that the continuing care of his

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BMJ 2001;323:563–5