LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*.
They should not exceed 300 words and should be typed double spaced

Post-traumatic stress disorder

Dr Field (January 1999 *JRSM*, pp. 35–37) castigates psychiatrists and psychologists for being too ready to diagnose post-traumatic stress disorder (PTSD) in reports for legal purposes. The disorder, he suggests, is 'nothing more than a collection of the psychological reactions that may occur after an emotionally traumatic event', and he questions whether it deserves special terminology. If we accepted this view, we would be faced with 'multiple morbidity' diagnoses—e.g. 'a moderate depressive episode with phobic anxiety and panic disorder'. Dr Field's comments on legal reports seem to indicate poor diagnostic practice. PTSD is the sum of various abnormal phenomena[1] and the reliability of diagnosis is increased by use of structured interviews[2] and psychophysiological testing[3] (which can help identify feigned symptoms). We accept his point regarding the seeming contradiction between two features of PTSD, hypervigilance and psychic numbing, but in our view these are not opposite extremes of an emotional scale but separate phenomena—as seen in depressive episodes where the patient is at the same time agitated and emotionally withdrawn.

We do not doubt the validity of PTSD, but Dr Field's paper does raise important questions about clinicians' understanding of the disorder and the criteria used for the diagnosis in legal reports.

Paddy Duffy
Chris Fox
Geoffrey Reid
Department of Community Psychiatry, Royal Air Force Brize Norton, Oxford OX18 3LX, UK

REFERENCES

1 Kendell RE. Diagnosis and classification. In: Kendell RE, Zealley AK, eds. *Companion to Psychiatric Studies*. Edinburgh: Churchill Livingstone, 1993:277–994
2 Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Charney DS, Keane TM. *Clinician Administered PTSD Scale for DSM IV: Current and Lifetime Diagnostic Version (CAPS-DX)*. Boston: National Center for Posttraumatic Disorder, 1997
3 Pitman RK, Orr SP. Psychophysiological testing for PTSD: forensic application. *Bull Am Acad Psychiatr Law* 1993;**21**:39–52

I hope that most psychiatrists and psychologists instructed on behalf of plaintiffs in personal injury litigation do not conclude that he or she is suffering from post-traumatic stress disorder (PTSD) *without* paying particular attention to the DSM-IV and ICD-10 diagnostic criteria.

From Dr Field's article the reader might conclude that PTSD is often diagnosed in a loose or even haphazard way, even by suggestion. In fact, this is what the diagnostic criteria specifically hope to avoid. This especially applies to Criterion A which describes the necessary magnitude and the impact of the traumatic stressor. In DSM-IV it is not enough to have been exposed to a trauma, it is also necessary that the survivor showed a strong emotional reaction such as fear, terror, helplessness, or thinking he or she was going to die. That is why the DSM-IV Criterion A has earned the reputation of 'the gatekeeper'.

When the diagnosis PTSD was first introduced in DSM-III in 1980, Criterion A was defined as 'Existence of a recognisable stressor that would evoke significant symptoms of distress in almost everyone'. This definition had two serious flaws that were corrected in DSM-III Revised (1987) and DSM-IV (1994). The 'recognisable stressor' needed to be much more specifically defined and research revealed that the 'distressing reaction' was more a subjective perception than an objective judgment. This is why the DSM-IV defined the 'gatekeeper' Criterion A much more precisely as:

'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'.

Therefore, according to DSM-IV, the traumatic stressor has to overwhelm psychological defences so suddenly and with such brutal force that no meaningful resistance can be offered. The imprint of such an event is then burnt into unconscious memory which stores sensations and emotions, and conscious memory which stores the factual element, probably in different parts of the brain.

The fact that young children are affected by traumatic experiences in much the same way as adults strongly supports the 'cascade' theory of PTSD. Recent research from Bath which looked at children who have been involved in road traffic accidents reminds us that children's needs are often forgotten. It would be difficult to sustain the notion that a 'barrage of leading questions' from an 'interrogator' could induce the nightmares and the repetitive play that authentically re-enacts the trauma.

The deep-cut traumatic memory imprint subsequently gives rise to a tenacious cascade of characteristic symptoms, collectively known as PTSD. Flashback memories lead to the development of protective avoidance behaviours which limit re-experiencing. The balance between the two changes over time. Emotional blunting follows, which