Post-traumatic stress disorder: a reappraisal

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It is virtually impossible nowadays to study a medicolegal report prepared by a psychiatrist or psychologist instructed on behalf of a plaintiff in personal injury litigation which does not conclude that he or she is suffering from post-traumatic stress disorder. Irrespective of the severity of the accident suffered or the clinical condition of the plaintiff, PTSD is the diagnosis.

The Diagnostic and Statistical Manual of Mental Disorders IV—and the *ICD–10 Classification of Mental and Behavioural Disorders* is broadly in line—states that the essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor with the subject's response involving intense fear, helplessness or horror.

There is no doubt that accidents or experiences in civil life may satisfy these preconditions but all too frequently the emotionally traumatic experience does not remotely approach an intensity sufficient to justify the diagnosis.

Thus post-traumatic stress disorder has been diagnosed after a miner slipped down some stairs after emerging from the pit bath and landed on his buttocks without any serious resultant physical sequelae. The diagnosis has been made on subjects who have been involved in minor rear-end shunts—in some cases when they have been asleep in a lay-by. Tripping over an uneven pavement has been considered to be of such emotional significance as to induce the condition. The mere process of being arrested is apparently so stressful as to induce PTSD—and that is so even when the subject has had considerable conflict with the law and has been arrested on many occasions in the past. Being knocked down by a bicycle has been judged so emotionally traumatic as to cause the subject to suffer from PTSD even when the physical injury sustained was so slight that the subject did not consider it necessary to attend hospital. A shopper was diagnosed as suffering from PTSD as the result of merchandise falling from a shelf and causing what could only be described as a trivial head injury. A professor of psychiatry diagnosed PTSD in subjects who had suffered serious head injuries with retrograde and post-traumatic amnesia and who, on regaining consciousness, were unaware that they had been involved in accidents.

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In none of these examples—and I can offer many others—could it be held that the subject experienced intense fear, helplessness or horror. That, however, has not prevented psychiatrists, psychologists, behaviour therapists, counsellors and community psychiatric nurses from making the diagnosis. Furthermore, in instances where an external observer might have doubted whether the stressor had been sufficiently severe, the problem was solved by the subject being asked directly—'Did you think that your life was in danger?'. Since many such subjects are plaintiffs in actions for the recovery of damages for personal injury and are only too well aware that the more dramatic their complaints, the greater might be their compensation, it is not surprising that the reply is very frequently in the affirmative. In fact, such subjects who have been asked this question will often say that initially the idea that their life had been in danger had never entered their minds. It was only when they were being interviewed for the purposes of the preparation of a medicolegal report or were being questioned by a psychologist in a stress clinic was the idea suggested to them. Many such subjects—especially those involved in road traffic accidents—say that the idea that their life had been in danger had never occurred to them because the accident in which they had been involved was, as it were, 'over in a flash' and before they had realized what had happened.

That experiences resulting in very severe emotional trauma occur in civilian life, there is no doubt. It has been described in individuals involved in earthquakes, volcanic eruptions or fires. Miners trapped underground by falls of rock with delay in their rescue fulfil the criterion as do passengers in an aeroplane hijacked by armed terrorists sitting behind them with weapons pointing to their heads. Lorry drivers trapped in a tunnel fire, passengers on a sinking ship and those involved in armed robberies are severely emotionally traumatized. What is apparent, however, is that all too often any traumatic emotional experience, irrespective of its severity, is regarded as sufficient to trigger PTSD.

ANALYSIS

DSM–IV states that the characteristic symptoms resulting from exposure to extreme trauma include:

- Persistent re-experiencing of the traumatic event
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and
- Persistent symptoms of increased arousal

Each of these criteria requires detailed examination.

Persistent re-experiencing of the traumatic event

Emotionally significant events—whether traumatic or pleasurable—are liable to leave a lasting impression on the mind. Depending on the intensity of the experience, the memory of the event and its accompanying affect will surface spontaneously from time to time or be triggered by some external happening. There are no grounds for regarding this phenomenon as evidence of psychopathology and yet it is a cornerstone of PTSD; indeed very frequently the condition is diagnosed on the basis of the presence of this particular feature alone.

Many subjects who have had accidents are involved in litigation. In those circumstances, they are required to attend for examinations for the purpose of the preparation of medicolegal reports and to discuss their experience with their legal advisors. They will be aware that at some time in the future they may be required to stand in a witness box and recount to a court all that occurred. The effect of all this is merely to keep alive in their minds memories which, under other circumstances, would gradually fade. In other words, ongoing litigation acts as an artificial reinforcing factor for unpleasant memories and their accompanying affect.

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness

When a person has been exposed to an emotionally traumatic event, exposure to similar circumstances or events will induce anxiety; this represents simple conditioning. It naturally follows that thereafter the person will avoid circumstances similar to those at the time of the trauma and will likewise avoid stimuli associated with or which remind him or her of the traumatic experience. This is simple phobic avoidance, a very common finding in everyday clinical psychiatric practice but regarded as a 'characteristic symptom' of PTSD.

Numbing of general responsiveness is a common feature of a depressive illness. Indeed, with anhedonia, such phenomena are characteristic of depression. These complaints are often accompanied by loss of interests and a failure to respond emotionally. Depersonalization frequently accompanies depression, although patients often have difficulty in describing how they feel—or rather how they fail to feel. Patients with the verbal capacity to communicate adequately will often say that they feel 'cut off' or estranged from those around them. Gloom about the future is all too common in depression, with the subject viewing the world through grey spectacles. Again, however, these symptoms—characteristic of depression and depersonalization—are regarded as criteria for the diagnosis of PTSD.

Persistent symptoms of increased arousal

The development of anxiety following emotional trauma depends on two factors. The first is the severity of the stressor and the second is the type of personality upon which the trauma is inflicted. Where anxiety is related to a particular circumstance (with consequent phobic avoidance of that circumstance and related stimuli), there is frequently, in addition, generalized anxiety. The subject feels 'on edge', is jumpy and startles easily. These reactions represent general anxiety, which frequently accompanies phobic anxiety. This phenomenon, too, is considered characteristic of PTSD.

DISCUSSION

Clearly PTSD is nothing more than a collection of the psychological reactions that may occur after exposure to an emotionally traumatic event. One might well question why it is deserving of special terminology. Well-established diagnoses such as anxiety, phobia and depression give a clear and specific indication of the subject's condition and the omnibus term post-traumatic stress disorder has nothing to recommend it.

Furthermore, in an effort to be all-embracing, PTSD results in phenomenological difficulties. Thus DSM–IV states—'The full symptom picture must be present . . .'.

It is difficult to envisage a subject in a state of high anxiety with irritability, hypervigilance and an exaggerated startle response simultaneously exhibiting psychic numbing, emotional anaesthesia and loss of general responsiveness. It is clinical nonsense to suggest that a patient can exhibit these contradictory psychological reactions—and yet if the preconditions for the diagnosis of PTSD are to be fulfilled, that must be so.

The question to be asked is whether prolonged exposure to severe emotional trauma (for that was the situation with combat veterans in Vietnam) results in a specific psychological syndrome characterized by features which do not occur in other psychological disorders and deserving of specific terminology. The evidence for such specificity is meagre.

It is not uncommon for a person to be stunned on being told of some disaster involving a dear one. Instead of reacting immediately with tears, depression or anxiety, the

subject remains emotionally non-reactive and only after a latent period displays what could be regarded as the appropriate emotional reactions.

There is a parallel between this and what is seen in clinical psychiatric practice. People who have been exposed to severe emotional trauma appear to react by becoming emotionally withdrawn and display what is described in DSM–IV as psychic numbing. Typically, the subject will say that events which formerly had evoked an emotional response from them no longer did so and that they did not, for instance, any longer enjoy their leisure pursuits or the company of their work colleagues. Characteristically, such persons will say that the wedding of one of their children failed to induce any feeling of pleasure, or the death of a relative or a pet did not evoke the grief that they would have expected. In other words, their capacity for emotional response is in abeyance. Only those who have been exposed to a horrific experience exhibit this phenomenon and it is not accompanied by flashbacks, intrusive memories, anxiety or the other symptomatology of PTSD.

The problem is that, on further investigation, the subjects do not admit to 'depression'; indeed their complaint is that they feel nothing. In fact, the subject is depersonalized. They will often say that they feel 'cut off' from the outside world and specifically from their family for whom they no longer feel affection. To what extent this depersonalization reflects the presence of an underlying depressive illness it is impossible to determine; suffice to say that not only is a lowering of mood denied but there is also an absence of what are regarded as the biological features of depression. Furthermore, in those individuals who have had antidepressive medication prescribed for them, this has been without benefit.

Since the phenomenon occurs after an emotionally traumatic event, it can certainly be described as post-traumatic, but whether what is essentially a state of depersonalization should be designated as post-traumatic stress disorder is open to question. Certainly without the presence of this crucial feature—emotional numbing—the concept of PTSD becomes meaningless.

CONCLUSION

The introduction of post-traumatic stress disorder into British psychiatry has been counterproductive. Patients and plaintiffs—and they are usually plaintiffs—are subjected to a barrage of leading questions with the interrogator having already made up his mind about the diagnosis and the subject only too well aware that giving positive replies might be to his advantage. The result is that post-traumatic stress disorder has now become an umbrella diagnosis and the term is indiscriminately applied. Its importation from the United States is a prime example of peer copying and its wholesale adoption by British psychiatrists and psychologists is regrettable.