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but separate phenomena—as seen in depressive episodes where the patient is at the same time agitated and emotionally withdrawn.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.

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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

effectively 'cocoons' the trauma victim away from triggers which stimulate unpleasant emotional reactions from specific reminders of the trauma as well as non-specific or partial 'cues'. Hyperarousal also develops with prominent hypervigilance and startle reactions. Those who have been traumatized never want it to happen again.

Unlike Dr Field I think that it is very easy 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'. Emotional blunting represents avoidance at an emotional rather than a behavioural level.

Dr Field concludes that 'PTSD is nothing more than a collection of the psychological reactions that may occur after exposure to an emotionally traumatic event'. That is precisely what it is and it is a remarkably cohesive constellation. Not only that; PTSD has proven to be a very useful way of explaining how trauma victims recover psychologically from life-threat because the symptoms should be viewed as initially having a strong survival emphasis, actually helping people to come to terms with a traumatic experience. The conventional view is that PTSD should not be seen as a psychopathology until the reaction has become 'stuck' and chronically disabling. Most people recover from this psychological injury with adequate support and by using their own resources; and most of those who do not will respond to treatment. The outcome can be very positive.

If Dr Field's views on PTSD were generally accepted, in the face of compelling evidence to the contrary, then many genuinely suffering victims (not only of combat or earthquakes, volcanic eruptions, fires and miners trapped underground) would not receive the help they deserve. Published research in Britain and other developed countries shows conclusively that victims of road traffic accidents and personal attack (rape, robbery, violence and mugging) commonly develop enduring PTSD as well as depression and anxiety states.

Should serious psychological injuries such as these not receive the perfectly legitimate attention of the Courts, as well as broken limbs? PTSD is a robust psychiatric classification based on high-quality research from all over the world of proven value for both clinical and medicolegal purposes. It fully justifies its place as a cornerstone in our understanding of how human beings respond to severe challenge. If it is what Dr Field terms an 'umbrella diagnosis' then it must be a particularly encrusted one since it was unfolded long before its 'importation from the United States'. Homer, Pepys and Dickens all described the core features of PTSD quite independently of DSM-III. If the American authors of DSM-III had simply been copycats they would have had to look no further than Lady Percy's description of her husband, Hotspur, after he had returned from the Wars of the Roses 410 years ago (*Henry IV, Part I*, Act II, Scene III, lines 42–69).

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Complementary medicine

The January 1999 *JRSM* contains both an editorial (p. 1) and an article (p. 13) on this subject. But what constitutes 'complementary medicine'? Professor Ernst, in his editorial, does not define it; Dr Chandola and colleagues define it as 'one that offers a holistic approach, in contrast to orthodox medicine that is supposed to view the body mechanistically', including acupuncture and 'manual healing methods' (which encompass manipulation).

Good orthodox medicine has always been holistic—in that the doctor is supposed to treat the patient rather than just the disease. Furthermore, what is regarded as orthodox medicine is constantly changing as it incorporates new therapies, some of which may have been used initially by those outside the medical profession—formerly known as 'quacks'. Acupuncture is now used by many registered medical practitioners both in general practice and in pain clinics. Likewise, manipulation is now frequently used by 'orthodox' practitioners including general practitioners, orthopaedic surgeons and rheumatologists. There is mounting 'evidence' of its efficacy; but one of the difficulties in designing suitable trials (particularly controlled ones) is defining the appropriate indications. As in all other fields of medicine, initial results will show successes and failures; it is the analysis of these that leads to identification of those patients most likely to benefit from a specific treatment.

In the case of back pain, many articles have compared manipulation with other treatments without defining the type of back pain—which is, after all, only a symptom. One would scarcely expect a comparison of treatments of headache, chest pain or abdominal pain to be of value without more definition of the 'syndrome' of symptoms and signs—even if one could not reach a precise pathological diagnosis.

We in musculoskeletal medicine are working towards the same goals as those in other fields—trying to prescribe the treatment most likely to benefit the individual patient.

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Professor Ernst (January 1999 *JRSM*, pp. 1–2) challenges complementary medicine to 'come up with the goods and demonstrate what treatments are effective, safe and cost-effective for which condition'. *Prima facie*, this would seem to represent common sense for any controversial issue in