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Post-traumatic stress disorder's future

Rosen *et al*'s editorial[1] raised problems associated with criteria that creep into the diagnosis of post-traumatic stress disorder (PTSD). Conditions including grief, relationship problems, dental care, abortion, traumatic television and humiliating events have entered the arena of PTSD. I support their appeal to psychiatrists to adopt a narrower definition, but beg to go further.

The DSM series has been invaluable for taking the science of psychiatry from its infancy to its adolescence of today. However, we now need to look towards maturity when we will use conceptualisations that involve true entities instead of symptom collections. What do we currently mean by PTSD? Both 'stress' and 'traumatic' are so non-specific they are now virtually meaningless – not to mention the 'P' and 'D'. According to the authors' concerns, the broadened concept of PTSD might euphemistically be described as 'Post Something Really Horrible Disorder (PSRHD)'.

Panksepp[2] proposed a preliminary taxonomy of distinct emotional modular systems (i.e. core emotions), supported by neuroscientific findings complemented by an evolution-based approach. I suggest that for the high-prevalence conditions comprising most of psychiatry, neuroscience without consideration of evolutionary adaptiveness is plain stupidity, as many of the relevant genes would not have persisted without adaptiveness.

Much of the PTSD bracket relates to the multiple forms of depression (a loss phenomenon) already catered for in the DSM. I have proposed that PTSD should be viewed as a disorder of defence involving extreme fear as the core emotion.[3] As such, some improvements to the DSM criteria can easily be accommodated such as differentiating the sleep disturbance associated with depressive ruminations from the listening for the 'bump in the night' of PTSD. Criterion C7 (sense of foreshortened future) should be scrapped as it clearly is depressive. Space here does not permit other commonsense improvements (see Cantor,[3] pp. 124–28).

The notion of 'Post Terrible Scare Disorder' might be a more scientifically valid concept, if lacking in elegance as a term.

1 Rosen GM, Spitzer RL, McHugh PR. Problems with the post-traumatic stress disorder diagnosis and its future in DSM–V. *Br J Psychiatry* 2008; **192**: 3–4.

2 Panksepp J. *Affective Neuroscience: The Foundations of Human and Animal Emotions*. Oxford University Press, 1998.

3 Cantor C. *Evolution and Posttraumatic Stress: Disorders of Vigilance and Defence*. Routledge, 2005.

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Rosen *et al* observed that the clinical presentation of PSTD is not restricted to those who have experienced severe trauma, that patients who are traumatised do not necessarily develop PTSD and that PTSD is often misdiagnosed.[1] We would add that there is almost no evidence that PTSD is reliably diagnosed in ordinary clinical settings. In our naturalistic study of expert reports about psychological injury after motor vehicle accidents, we that found that the agreement about the presence of PTSD by experts engaged by the same side in the court case was little better than by chance.[2] Most of the disagreement seemed to be due to selective use of the diagnostic criteria, although there was also difference in opinion about the severity of the patients' experiences and hence whether they met the 'A' criteria.

A search of PubMed, PsychLit and CINHAL did not locate any studies to show that PTSD can be reliably diagnosed without the use of a structured or semi-structured interview. The DSM–III and ICD–10 field trials did not report the interrater reliability of PTSD[3,4] and the DSM–IV trials restricted the examination of the reliability to the rating of audiotapes of 25 patients' responses to the PTSD module of the Structured Clinical Interview for DSM.[5] Furthermore, we have not been able to ascertain whether the very high kappa scores reported in the DSM–IV trials (κ=0.85) included a correction for the loss of degrees of freedom arising from the use of the same ratings in multiple-rating pairs.

Although there are numerous studies confirming the interrater reliability of various diagnostic instruments, many of the instruments are only administered when the patient is suspected of having the disorder, and their ability to reliably distinguish PTSD from other disorders is not well established. Despite their limitations, we support the call of Miller[6] for the routine use of diagnostic interviews, as there is no evidence the disorder can be reliably diagnosed in any other way.

Rosen, Spitzer & McHugh call for DSM–V criteria that reflect research findings and limit the potential for misuse of the diagnosis. We believe that the logical step would be the complete removal of the A criteria. This would separate the clinical assessment of the patients' psychological state from issues of causation and minimise pre-emptive decisions about the cause and nature of the patient's distress. This new disorder, which could be called 'phobic memory disorder' or another name that does not imply a particular cause, could then be diagnosed in the usual way. As there are likely to be few objective features of the disorder, the diagnosis should be made using a semi-structured interview for the new criteria. Causative factors, including the role of trauma, premorbid conditions and litigation, would be considered in the same way as in other disorders.

1 Rosen GM, Spitzer RL, McHugh PR. Problems with the post-traumatic stress disorder diagnosis and its future in DSM–V. *Br J Psychiatry* 2008; **192**: 3–4.

2 Large M, Nielssen O. An audit of medico-legal reports prepared for claims of psychiatric injury following motor vehicle accidents. *Aust N Z J Psychiatry* 2001; **35**: 535–40.

3 Spitzer RL, Forman JBW, Nee J. DSM–III field trials: I. Initial interrater diagnostic reliability. *Am J Psychiatry* 1979; **136**: 815–7.

4 Sartorius N, Ustun TB, Korten A, Cooper JE, van Drimmelen J. Progress toward achieving a common language in psychiatry, II: Results from the international field trials of the ICD–10 diagnostic criteria for research for mental and behavioral disorders. *Am J Psychiatry* 1995; **152**: 1427–37.

5 Kilpatrick DG, Resnick HS, Freedy JR, Pelcovitz D, Resick PA, Roth S, van der Kolk B. The posttraumatic stress disorder field trial: emphasis on Criterion A and overall PTSD diagnosis. In *DSM–IV Sourcebook Volume 4* (eds. T. Widiger, A. Frances, H. Pincus, R. Ross, M. First, W. Davis, M. Kline): 303–44. American Psychiatric Press, 1998.

6 Miller PR. Inpatient diagnostic assessments: 2. Interrater reliability and outcomes of structured vs. unstructured interviews. *Psychiatry Res* 2001; **105**: 265–71.

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