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Editorial Note: Among the goals of this Journal is public discourse: to stimulate the community of traumatologists to question, assert, debate, and fully discuss critical issues of the field. Dr. Straton, an Australian psychiatrist, wrote a series of messages in the course of a debate on the Traumatic-Stress Forum recently. This essay evolved and was stimulated by that lively debate. Among other things he was asserting that that the policies that are intended to support war veterans cause them to receive sub-optimal mental health treatment. He believes that two important articles available on line (Yahuda & McFarlane and Levy) both illuminate and extend his points. In keeping with the value of the Journal, the Board of Directors and I believe that readers of the Journal will benefit from this thread and, we hope, write reactions to it.
--Editor

The Trouble with PTSD

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I frequently get asked to assess veterans of WW11 and Vietnam who are claiming a war-related injury pension. They get referred to me by both sides; the Dept of Veteran's Affairs (DVA) and also by the agent of the Returned Servicemen's League (RSL) who helps veterans appeal against rejections by the DVA.

The consequences of these assessments in Australia can be large. If someone gets judged 'Totally & Permanently Invalid' (TPI) they get a pension of about $1100 per fortnight tax-free for life. They get other benefits like free medical care, and tertiary education for their children. Overall this costs the tax-payer about $1 million a time.

The context of these assessments is relevant. They have all been provided with the DSM-IV criteria for PTSD by the RSL before I see them.

You get the picture? Vet knows various mates who have the TPI or less. RSL agent suggests he has a crack at it. He takes PTSD criteria home to the wife and they pore over them. 'If you say yes to this, we could get a new kitchen!' The catechism is carefully swotted. Symptoms are dusted off and polished. An appointment is made; about a month to wait. Usually this will be the first time he has ever seen a psychiatrist.

Did you hear the story of the DSM-IIIR diagnosis for PTSD that got into the hands of the Veterans organisation? That diagnosis included an item on 'Survivor Guilt'. Unfortunately the letter that got sent out to the Veterans organisations had a misprint; 'Survivor Quilt'. I guess this happened at the time of AIDS quilt making. Anyway, I heard that a number of assessing psychiatrists were bewildered to have veterans spicing their stories of trauma and flashbacks with the comment; 'and I'm knitting a survivor quilt'!

My main point is not to criticise veterans and other claimants for compensation on the grounds of PTSD as being malingerers and rorting the system. My target is the diagnostic category of PTSD (DSM-IV 309.81). I think it is flawed theoretically and practically. I also think that special veterans health services are probably 'sickening', in that they generate worse health status's in the people they are intended to help.

I think that once a diagnosis gets entangled in compensation and litigation issues, we clinicians and researchers should abandon it as a scientific entity. The populations described by it will be hopelessly contaminated by members sneaking in the door for financial purposes, or suitable members being left out of it because it would cost the public purse too much if the definition was such that they were let in.

The Trouble with PTSD: Theory

HL Mencken said: "To every complex question there is a simple answer, ... and it's wrong."

He could have been talking about PTSD.

The history of the Human Sciences this century has been the move from reductionism and determinism towards more complex and sophisticated models such as General Systems Theory.

Reductionism reduces aetiological factors ultimately to a single cause, such as a specific 'mad molecule' of the sort that has been sought (unsuccessfully) to explain schizophrenia.

Determinism tries to reduce causal relationships to linear ones, of the general type 'A causes B'.

General Systems theory deals with the ideas from different levels, such as biological, psychological, and social. It also incorporates the option of circular relationships, such as positive feedback loops.

Existentialism focuses on the experience and meaning of the person who is suffering the condition.

The nosological systems used in psychiatry have gradually accommodated to these developments.

But it certainly irritated the lawyers and the insurance companies. They wanted clear-cut lines, and unambiguous causal relationships. They didn't want the waffle that psychiatrists were spouting in the expert witness stands. Here's a quote from an article (1) about the legal use of PTSD.

> *"Like pregnancy, PTSD is defined as something that one either has or does not have: for medico-legal purposes, there are no "shades of PTSD grey" (even though in actuality and in some current research, the condition is viewed more in terms of a gradient of symptoms.)"*

Mencken was right.

The victims of trauma didn't want anything said that had the slightest whiff of 'blaming the victim'. They didn't want any talking of predisposing vulnerability, unconscious conflicts or other matters that might dilute the power of their complaint against whoever was responsible for their suffering.

So the soil was fertile for a fallback to a more primitive epistemology. A deterministic, reductionist definition for trauma pathology. So a concept was born, in 1980, in DSM III, in which the condition was defined primarily in terms of its cause, rather than it's phenomenology.

The academics were happy. The victims were happy. The lawyers were ecstatic.

The trouble was, it was based on a lie.

An analogy for the development is this: Lets ask the question, 'If a glass falls off a table, will it break?'

Blind Freddie can see the answer, 'It depends'.

It depends on:

- The qualities of the glass.
- The height of the table.
- Whether it hits carpet or concrete.

The lie behind PTSD comes in the form of a plausible simplification. In effect, by the clause in DSM-III and III-R 'outside the range of usual human experience and that would be markedly distressing to almost anyone', the position is being put up that one can ignore the qualities of the person and their context if the trauma is large enough.

It's as if they said, 'If the glass falls from 10,000 feet, it doesn't matter what sort of glass it is, or what it hits.'

Well maybe not, but the thin end of the wedge was introduced.

Because once you have retreated to reductionist determinism, where are you going to stop?

PTSD is, I think, the only category in the DSM-IV which is defined primarily by it's cause. It is a dehumanising category which reduces people to the status of car-wrecks. It includes an implied aetiology in it's definition that renders all debate on aetiology tautological. It creates an arbitrary cut-off point in the scale of severity of trauma, which moves from edition to edition. It diminishes human variability and the powers of resilience and recovery. It is a retrograde step in the development of a humanistic, holistic science of persons.

The truth is that reactions to trauma can certainly be severe and debilitating. They certainly vary from one person to another (2). Some vulnerable people get big reactions from smaller traumas. Some tougher people only get reactions from bigger traumas. The context is often important. The matter is very complex, and often uncertain.

The Trouble with PTSD: Practice

I have found that when I criticise the diagnosis of PTSD, some people take offence because they assume I am denying that some people suffer severe consequences after serious trauma. That is not the case. I will try to explain some key concepts.

Nosology is the study of the classification of disease. Epistemology is the branch of philosophy concerned with knowledge. The two main epistemological positions on nosology are:

- Realism.
- Nominalism.

If you don't know the difference, you are probably a realist. If you think the question 'does PTSD exist?' is a sensible question, you are certainly a realist.

I am a nominalist.

The distinction between a nominalist and a realist is not that a nominalist doesn't believe that there is some phenomenon that is being named. It is that the name of a thing is not the same as the thing that is being named. It is essentially that there is a difference between the map and the territory. I am not merely a nominalist when it comes to PTSD, I and most people who have studied the subject hold a nominalist position with respect to all diagnoses.

I will try to illustrate the point with some analogies. A nosological system is a method of navigating in the ocean of pathology. Lines of longitude and latitude are devices for navigating on the ocean of water. A realist is someone who confuses the cultural constructs of lines on the chart with real phenomena. They might think that you can sail up to the equator and tie up to it.

There are phenomena with natural discontinuities. There is a genetic difference between various micro-organisms. There is an atomic difference between certain chemicals. There is a physical discontinuity between, say, California and Hawaii, or the Australian mainland and Tasmania. But there are other phenomena where the discontinuity between them does not lie in nature, but rather in culture. California vs Nevada, Queensland vs New South Wales, etc. There the line is drawn by humans for historical and political reasons. These are the lines you see on political rather than physiographic maps.

Psychiatric nosology is like a political map. There are, so far, no demonstrable discontinuities in nature to underpin the different conditions and the boundaries between them. There are, of course, other ways of defining them, just as there is for the equator.

When it comes to dealing with the essence of a condition, this probably doesn't matter. Whether it is core depression, core panic, or core trauma reaction. But when one is adjudicating whether an individual person lies one side of a boundary or the other, it is quite important to understand what sort of boundary one is talking about.

Diagnoses are assessed according to a number of criteria:

- **Reliability**
- **Validity**
- **Utility**
- **Morality**

Reliability basically means the degree to which several different clinicians, working from the same criteria, will come up with the same answer. The issue arises in all areas of medicine, and a good figure is 80%. The more tightly defined the criteria, the better the figure.

It is also the case that diagnoses assessed for reliability on 'naïve' populations (who don't know the criteria they are being assessed for), may have entirely different levels of reliability when being used on populations who are not naïve, and are highly motivated to fit the diagnosis.

I'm sure the WISC would lose reliability if some kids were given the answers a few weeks before they were to be tested with it.

Validity means the degree to which the diagnosis corresponds to some external measure of whether the condition exists. In much of medicine that can be measured against pathology findings including post-mortems. In psychiatry, it usually is linked to response to treatment, or prognosis.

Note that Reliability and Validity may have a reciprocal relationship; if you define things extremely tightly, you may get better reliability, but your validity figures may go down because you have left out cases who have the essence of the condition.

Utility means usefulness, This may be influenced by the availability of effective treatments. For example, before the discovery of lithium the utility of differentiating Schizophrenia from Manic Depressive Psychosis was limited, because both conditions would have been treated the same, usually with antipsychotics. After lithium, the utility of the Manic Depression diagnosis went up.

Morality is primarily whether the act of applying the diagnostic label to someone is beneficial to them. Claude Steiner used to say that any diagnosis ending in '-ic' was not a diagnosis, it was an insult. E.g. schizophrenic, or alcoholic.

These four tests are the ones used for the development of medical diagnoses. Similar ones are used for the development of psychological tests and questionnaires.

In the real world of clinical medicine, these tests are probably enough. They enable clinicians to know what they each mean when they are communicating with one another.

However, once a diagnosis becomes important in the world of social administration, these tests alone may no longer be enough. Examples of social administration arenas include court cases, pensions, diagnostically conditional health insurance, and compensation. These are areas in which mere clarity is insufficient. They are areas in which there are profound and powerful forces that may lead to movement across any boundary.

To use an analogy, a white line is fine as a boundary on a tennis court. But it won't keep goats in.

The more powerful the force operating across a boundary, the stronger it must be to fulfil it's function. When major gradients of finance or freedom are involved, very strong boundaries are necessary. The Soviet Union would not have stopped their citizens from fleeing into West Berlin with a single strand wire fence. They had to build the Berlin Wall. The gradient of wealth between Mexico and Texas is considerable. I doubt that a white line would control migration.

The defining characteristics of PTSD were established by academics interested in clarity. They

are intended to answer the question, 'What exactly do you mean by the term xxxx, Doctor?' The criteria are like a line on a tennis court. They may be sufficient for research populations, and people with no material interest in whether they have the diagnosis or not. They may work with naïve populations who have no idea what they are being tested for.

But the diagnosis of PTSD, more than any other, has become the football of litigation, compensation, and the administration of veterans benefits. Huge numbers of people, and vast sums of money, hinge on the question of whether or not someone fits the PTSD criteria. The people being tested for it mostly know the criteria, either because they are told by a veterans agent, or because they can read the criteria for themselves on the Internet.

In this situation, the four tests for judging a diagnostic category are not enough. Another is needed;

Verifiability.

And the present criteria don't come near that by a country mile.

Lets look at them.

Imagine yourself as someone who is hoping for a pension. As I mentioned above, in the Australian Veterans case of Total and Permanent Disability (TPI) this is about $1100 per fortnight, tax-free for life. Throw in free tertiary education for your children, free medical care, etc. After a months wait, you front up to the psychiatrist who runs you through the PTSD criteria.

> *A1. Anyone who was in a theatre of war could say they witnessed a threat to the physical integrity of others.*
>
> *A2. 'I felt intense fear. Scouts honour.'*
>
> *B. Only one out of 5 needed. Let's go for B4. 'I jump out of my skin when a car back-fires'.*
>
> *C. 3 out of 7 needed. How about C 1, 2, and 5. 'Don't like to talk about it (C1), Won't go to the RSL club or watch war movies (C2), I feel detached from X, Y, & Z.' (C5).*
>
> *D. 2 out of 5 needed. Easy. 'My sleep is patchy (D1), and who are you calling irritable, Dickhead!!' (D2).*
>
> *E. More than a month since Vietnam ended.*
>
> *F. 'It causes me significant distress. Scouts honour.'*

No worries. What colour kitchen do you want, Mabel?

OK. Hands up. Who couldn't imagine telling a few white lies if they thought $1,000,000 was at stake? Especially if a lot of it was true? And you had had a tough time in the war, and you were conscripted, and frightened, and you had drunk too much since and been taken to the cleaners by a couple of wives, and you are finding it difficult to keep a job, and you are worried about money.

Do I have any takers?

Line up over there for research into L.I.A.R. (DSM V. 59982.8876). Or if you prefer, Gullible Personality Disorder (DSM V 32451.8662)

The truth is that the boundaries of the PTSD category are insufficiently falsifiable or verifiable to sustain the gradients of financial importance to the people close to them. The concept is unworkable in the real world in it's present form.

The Trouble with PTSD: Veterans health services

I feel strongly about the points I made in the first two sections of this article. This one is different. I have a suspicion. Not a certainty.

The suspicion is that those health services that are dedicated to the welfare and health of veterans, are, in large part, sickening.

The term is Ivan Illich's, he uses it in his books 'Medical Nemesis', and 'The Limits to Medicine'. He means that the social arrangements for the promotion of health actually produce more sickness.

The US, Australia, the UK, and New Zealand all took part in WW1, WWII, and Korea. All except the UK took part in Vietnam.

The US and Australia have special health services for veterans.

The UK and NZ put their veterans through the normal health service.

I have worked as a doctor in the UK, NZ, and Australia. It is my strong impression that the veterans in Australia have worse health than those in the UK or NZ. All psychiatrists I know who have worked in both NZ and Australia agree. The Australian veterans get paid to stay ill. You get the bizarre and tragic sight of countless otherwise proud old warriors carting their diseases round endless assessments by endless doctors, trying to get someone to support a link between, say, a heart attack in the 1990s, and a battle in New Guinea in 1943.

Don't get me wrong. I believe that anyone that risks their life for me, my children, or my country, deserves the best possible financial support , and the best possible health treatment. But 'best' should surely mean, 'best outcome', not 'best intention'. My question is whether the provision of support and health care in a way that is conditional on staying sick is really health promoting. I suspect it is not.

Recent world history is full of examples of well intentioned social movements that caused havoc to their intended beneficiaries. The Soviet Communist Party is one that comes to mind. I suspect that the Department of Veterans Affairs is another.

A good subject on which someone might do an international comparative study?

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