Correspondence
Edited by Kiriakos Xenitidis and Colin Campbell

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Post-traumatic stress disorder’s future
Rosen et al’s editorial1 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’ concern, the broadened concept of PTSD might euphemistically be described as ‘Post Something Really Horrible Disorder (PSRHD)’. Panksepp2 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 depression from other disorders is not well established. Despite their limitations, we support the call of Miller4 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.


Rosen et al observed that the clinical presentation of PTSD 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.5 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 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.6 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 PTSD3,4 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.3 Furthermore, we have not been able to ascertain whether the very high kappa scores reported in the DSM–IV trials (k=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 Miller5 for the routine use of diagnostic interviews, as there is no evidence the disorder can be reliably diagnosed in any other way.

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Authors’ reply: We welcome the responses by Cantor and Nielsen & Large to our editorial. On the lighter side, we observe that yet more proposals for post-traumatic conditions are proposed by Cantor (e.g. PSRHD), thereby demonstrating an ever increasing incidence of ‘acronymitis’. This disorder, characterised by a seeming compulsion to develop acronyms, was to the best of our knowledge first labeled by Isaac Marks (personal communication, 2005).

On a more serious note, we would like to use our limited space to highlight several observations that we have taken from an extensive review of the PTSD construct. This review proposes that PTSD’s defined clinical syndrome might best be conceptualised as encompassing a broad range of reactions to adverse events that are in turn influenced by multiple dimensionally distributed factors (e.g. pre- and post-incident risk variables, peri-traumatic appraisals and real-life consequences). The long history of general stress studies, and more recent research on PTSD, has demonstrated that these multiple factors and their complex interrelations yield a wide range of outcomes after adverse events. Within this framework, it remains an open question whether any attempt to define a distinct post-traumatic syndrome can lead to a true disorder in nature that is specific to a subset of stressors. Perhaps such a disorder exists, and PTSD or some other acronym should remain in the psychiatric nomenclature. For the moment, however, it appears that the very literature spurred by the creation of PTSD has demonstrated, somewhat ironically, that the construct is flawed. It is in the context of these concerns that we acknowledge issues raised in the Journal’s letters and encourage continued discussion on the validity of the PTSD diagnosis.

Lithium in mood disorders: a one-sided re-appraisal

To the uncritical mind, it appears as if Young & Hammond¹ have made a case for more use of lithium in mood disorders than is currently the trend. They partly based their argument on the meta-analysis by Smith et al.² A close perusal of the meta-analysis, however, revealed that the case made by Young & Hammond for lithium is one-sided, unbalanced and may be misleading. Even though the study by Smith et al.³ stated that lithium remains the medication with the strongest evidence base, we believe that its declining use may be due to incontrovertible evidence of adverse effects. For example, in the meta-analysis by Smith et al., when withdrawals for any reason and withdrawals for adverse events were analysed, there were more withdrawals with lithium compared with lamotrigine, valproate semisodium and olanzapine. Even in terms of efficacy, the choice of lithium remains arguable. For example, when relapses due to depression were analysed, Smith et al.⁴ found that there were more relapses with lithium than with lamotrigine and valproate semisodium. In terms of manic episode, there were more relapses with lithium compared with olanzapine, and in terms of any mood episode, there were more relapses with lithium than valproate semisodium and olanzapine.

We do not advocate for any particular medication but we strongly feel that for this type of medication advocacy, authors should attempt to provide a balanced rather than one-sided argument. It is also patronising to partly ascribe the declining use of lithium to poor training of psychiatrists rather than acknowledge the fact that psychiatrists may actually base their choices on individual patient criteria as well as the profile of medications within the wide array of available agents.


Authors’ reply: We are pleased that Adetunji et al read our paper and saw fit to comment upon it. However, we are surprised at the nature of their remarks, which suggest that not only did they not read our piece with particular care, they have perhaps also not thoroughly read (or perhaps understood) the paper they quote by Smith et al.⁵ One of us (A.H.Y.) is the senior and corresponding author on this meta-analysis and thus very familiar with the content! Close perusal of our meta-analysis does not show our case for lithium to be one-sided, unbalanced and misleading. Indeed, we conclude ‘mood stabilisers have differing profiles of efficacy and tolerability’ and demonstrate that lithium has clear evidence of both tolerability and efficacy. Nowhere do we suggest that lithium is the best treatment for every patient with bipolar disorder, nor is the purpose of the article to review the evidence for all bipolar medications. Rather, as we state in our conclusion, our argument is that lithium remains the best treatment in a significant portion of cases and must be included in any psychiatrist’s treatment arsenal. The reason this message is so important is that lithium is increasingly being neglected as a treatment option in several countries, resulting in inadequate treatment of some patients with the disorder, who are then labelled ‘treatment-resistant’ without having ever tried lithium.⁶

Prescribing patterns are influenced by pharmaceutical company promotion – or why would companies spend this money?⁷ Jefferson¹ and Chan¹ both report declining psychiatry resident knowledge about, and use of, older medications (including lithium) despite evidence supporting their continued use; we are unclear why Adetunji et al find this literature ‘patronising’. We agree with them, however, that psychiatrists should base treatment choices on individual patient characteristics as well as the profile of medicines. Applying this approach to the wide array of available agents will undoubtedly ensure that lithium continues to be widely used for the foreseeable future.


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