Post Traumatic Stress Disorder revisited

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Recently on the ABC's *Four Corners* programme featuring Post Traumatic Stress Disorder (PTSD), some of the perceptions that I have heard spoken from time to time were pointed out. For example one prominent psychiatrist feels that 95% of PTSD diagnosis are incorrect. Certainly from my experience there are some incorrect diagnoses that I come across but would not have placed the figure at 95%.

Some people have even gone to the extent of equating PTSD with RSI (repetitive strain injury). The latter was a particularly Australian affliction that gathered a number of disorders under the one flag, while the existence of the former is gathering world wide acceptance. Some very impressive research has been conducted to indicate a possible organic basis. For RSI, there was a rush of litigation as we all know, and it has now died down. This has not happened to PTSD.

The legal system may have some problems accepting the widening knowledge about PTSD. For example, Dr Lennane pointed out in *Four Corners* that repetitive stress can accumulate to produce PTSD and she indicated there had to be a present a threat to the person's psychological existence. A example of such a situation is where someone is repetitively abused in the workplace and his or her whole livelihood is threatened by this "mobbing behaviour". Whistle blowers are often the victims of this behaviour in the workplace. Also there is the increasing recognition of risk factors other than trauma, such as disturbed childhood premorbid states etc. [1]

It has been merely 17 years since PTSD was recognised as something different, and as is in the law, there has been and continues to be the usual social discourse: in this case, scientific investigation and development of the PTSD concept to the fullest. Because it has such a ready application to the legal process, the law is having more than its usual influence, which has added another dimension to this discourse.

The neurobiological underpinning to the disorder is starting to take shape. Prof A Y Shalev from Jerusalem University in Israel, in a recent visit to St John of God Hospital Burwood, Sydney, described his investigation of the effect of the rush of Cortisol during the trauma. He believes that on various scans and other radiological investigations, it is possible to see shrinkage of certain areas of the brain in the limbic circuit following the trauma. It can be speculated that these have been damaged by the high concentrations of Cortisol associated with the trauma.

There is then increasing evidence that PTSD is not simply an extension of normal stress reactions as may have been previous assumed in research. It is not simply a disruption of the hypothalamic-pituitary-adrenal (HPA) axis but rather, "*PTSD sufferers show evidence of a highly sensitised HPA axis characterised by decreased basal Cortisol (after the possible shrinkage in certain areas of the limbic system) and increased negative feedback regulation. Studies of psychophysiologic electro-physiologic, and neurochemical alterations have revealed similar abnormalities of the sympathetic nervous system and other neuro-modulatory systems*".[2]

It is important to realise that knowledge about PTSD is in flux more than most diagnoses and that this more than most diagnostic labels *"only works if both the person applying the label and the person interpreting the label have exactly the same understanding of what the label means. If they do not, the label has not only ceased to serve a useful purpose but it actually may contribute to the dissemination of misinformation"*.

There can be little doubt that PTSD is a real and distinct entity that has survived the rigours of scientific investigation and will continue to survive and grow. More research will determine the neurological, psychological, and biochemical basis for it as well as the psychological and social factors that may predispose and affect it generally. As this occurs, legal discourse will adjust to these realities of a clearer understanding of PTSD especially in forensic psychiatry, as this is the only discipline that encompasses all these research areas as well as attempts to complete an understanding of the patient and their environment.

There may be different subtypes of PTSD, with varying degrees of organic, psychological and social influences underlying each subtype. Certainly some of the symptoms seem similar to chemically based depression. The dissociative symptoms may be more psychologically based and the symptoms involved in re-experiencing the traumatic could be more socially influenced. Clearly there needs to be more research on the origins of the individual symptoms and where they should fit into the syndrome.

Despite the discomfort of some, PTSD is here to stay and will help elucidate the phenomenon of stress and the heated debate that rages around it. So get out your DSM IV and prepare for more and better of the same. If you can't fit the patient/client into the criteria for this diagnosis don't forget Adjustment Disorder and all the rest. Don't forget though that PTSD is a very distressing condition and if there is not intensity in the symptomology, it is not post traumatic stress disorder.