

POSTTRAUMATIC STRESS DISORDER (PTSD): A TAILOR-MADE DIAGNOSIS FOR AN AGE OF DISENCHANTMENT AND DISILLUSIONMENT?

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*„Can anybody remember when the times were not hard,
and money not scarce“*

Ralph Waldo Emerson

Post-traumatic stress disorder (PTSD) is one of the most controversial diagnosis in psychiatry as well as in medicine in general (Jakovljević 1998, Stein et al. 2011). PTSD has probably been with us for thousands of years, but it was not until 1980 described as the nosological entity (DSM-III, APA 1980). PTSD was initially defined as a characteristic pathological condition which follows a psychologically traumatic event that is generally outside the range of usual human experience (APA 1980). According to that definition the symptoms result from the trauma exposure. DSM-III and DSM-III-R (1987) processes recognised that differently labelled syndromes like post-Vietnam, war-sailor, rape trauma, child-abuse, concentration camp syndromes, etc. were all characterised by a very similar pattern of three symptom clusters: the trauma re-experiencing or intrusive memories of it, emotional numbing or the avoidance of stimuli associated with the trauma, and increased autonomic arousal that formed PTSD diagnosis (Friedman 2011). Prior to the Vietnam war, conventional wisdom was that war indisputably created psychological breakdown (Jones & Wessely 2003). Provided the condition was neither medicalised, hospitalized nor financially rewarded, then the breakdown would be curable and short-lived (Shepard 1999, Jones & Wessely 2003). If it was not short-lived, then it was the consequence of mismanagement, poor inheritance and/or disturbed early upbringing, and war was merely a trigger. So psychological symptoms related to combat experiences were normal responses to abnormal situations and were transient unless treated in ways that increased secondary gain (Wessely 2005). The DSM-III changed this by stating that the cause of chronic as well as acute breakdown after combat was still the war itself, and that everyone had a breaking point if subjected to sufficient stress.

According to DSM-IV-TR PTSD is defined by exposure to a traumatic event in which a person experiences, witnesses, or is confronted with the threat of death, serious injury, or a threat to one's own physical integrity resulting in intense fear, helplessness, or horror (APA 2000). After the wars in former Yugoslavia, PTSD from the Cinderella diagnosis became the most

popular and beneficial diagnosis in Croatia. Both patients and their physicians are keen to exchange their less attractive diagnostic currencies for one that yields more, even if to paraphrase Scott (2005), it sometimes means less. The PTSD diagnosis has been inflated and this inflation raises a lot of epistemological, ethical, and axiological as well as social and political questions. In general, there is growing concern that there may be distortions in the PTSD data bases due to exaggeration or malingering related to secondary gain incentives among veterans. It seems that the true origins of PTSD inflation lie more in post-war Croatia, and not so in the war itself as it was the case with Vietnam veterans (see Wessely 2003). The post-war economic and political climate with rising unemployment rates and loss of social security has fostered a sense of disappointment, personal injury, embitterment and grievance as well as demands for compensation. Secondary victimization or revictimization of Croatian veterans with PTSD diagnosis was significantly associated with the process of compensating pensions and other benefits as well as with the paucity of general social support and paradoxical law (Vukušić et al. 2003). It seems that the role of post-war belief, expectation, explanation and attribution is of great importance in addition to the consequences of combat itself. The posttraumatic embitterment syndrome (PTED), as recently described by Linden (2003), could contribute to better understanding of the PTSD diagnosis inflation in Croatia. PTED is a universal reaction type that is frequently seen in individuals who are exposed to events of personal injustice, humiliation, frustration, and helplessness associated with a prolonged feeling of embitterment (Linden et al. 2007).

Keep Them on the Road and Keep Them Moving

This concept of Milton Erickson could be fruitful in our assesment of pesimistic and optimistic view on the progress made in the field of PTSD and psychotraumatology. With regards to the conceptualisation of trauma spectrum or trauma-related mental disorders and

PTSD a key question is whether we are now on the right or on the wrong road.

A pessimistic view on PTSD is that we are on the wrong road because there is no disease entity corresponding to what we call PTSD. PTSD is useless as a medical diagnosis and its use does more harm than good. It carries no useful treatment implications, but it is liable to lead to needless chronicity and worry. It is irredeemably contaminated by litigation (Scott 2006). In fact, PTSD is surely not a true medical diagnosis, rather it is best seen as a medicolegal, benefit-linked criterion. Recent years have seen an expansion of PTSD-related disability-seeking and litigation (Frueh et al. 2005). It is a bureaucratic hurdle for a claimant to surmount, not a medical diagnosis with implications for treatment and cure (Scott 2005). Financial incentive may influence the presentation of post-event symptomatology with symptoms over-reporting, potential malingering, and bias in self-reported trauma exposure history (Frueh et al. 2005). According to postmodern psychiatry PTSD is „a tailor-made diagnosis for an age of disenchantment and disillusionment“ (Summerfield 2005).

An optimistic view is that we are on the right road, but we are dealing with a very complex clinical condition on the very border between normality and pathology. The inclusion of PTSD in DSM-III was a significant progress that enriched our knowledge in psychotraumatology and our ability to offer appropriate care to traumatized individuals (Brewin 2011). We have learned much about the kinds of trauma that are typically followed by PTSD, about the natural course of symptoms in response to such traumas, about reliable ways to evaluate and measure PTSD symptoms, and about appropriate treatment and community approach. The many models of the PTSD are not mutually exclusive and they address different levels and dimensions of the traumatic stress response complexity.

Psychotrauma between danger and opportunity: the losses and the gains

Psychotrauma is one of the key concepts in the psychopathology and etiology of mental disorders in general and it is not related only to the etiology of PTSD which is by definition a consequence of traumatic stressful life events. The key question in psychotraumatology is why some individuals develop and some do not develop PTSD following exposure to potentially psychotraumatic events. Trauma can be seen as the precursor of negative as well as positive changes (Park 1999), but the ancient idea that people can experience trauma-related growth has been commonly neglected in psychiatry. Traumatized individuals commonly divide their lives between before and after the trauma which leaves a deep and enduring imprint in their personality and life philosophy. Their response reflects the appraisals and subjective meaning they assign to the experience (Park 1999). The key point of appraisal theory is that „the way we evaluate an event determines

how we respond emotionally“ (see Troy & Maus 2011). Once one has been confronted with life-and-death situation trivial no longer matters, the perspective may grow for a life at a deeper level (Demartini 2006). Research to date documented the fact that many trauma survivors report feeling as though they possess newfound wisdom and a rediscovered sense of appreciation for life, and a better sense what is truly significant (Park 1999). So, really or potentially traumatic stressful situations are chances for us to do our best. Emotions involve rapid nonconscious appraisals of events which are significant to the person and represent reactions to fundamental relational meanings that have adaptive purpose (Schore 2002). Many events cause pain, fear, anger, horror and other negative emotions, but which would cause pleasure if we regarded their advantages. Obtaining wisdom, restructuring the life narrative in posttraumatic growth, a sense of purpose in life, establishing life principles that are robust to future challenges, and resilience restoring are crucial (Tedeschi & McNally 2011). PTSD may be a life transforming experience with moving even toward a level of functioning better than one's pretraumatic level.

Resilience can be defined as the ability to bounce back from tough and trauma times or even to triumph in the face of adversary. It includes positive adaptations in response to stressful event, such as developing new insight or strengths that improve functioning or well-being (Meyer & Mueser 2011). An ability to reframe the things, most notably moving from feeling disappointment to seeing opportunities is an important aspect of the resilience. Resilience is not only intrapsychic and neurobiological phenomenon, rather it is related to the transaction or interaction between the person and her or his environment. While much has been learned about trauma-related psychopathology, deficits in psychosocial functioning and PTSD, far less is known about resilience to trauma and capacity to experience negative life events without developing mental disorder. The ancient idea that tragedy and suffering can trigger personal transformation and growth (see Tedeschi & McNally 2011) is very compatible with „the concept of positive mental health as the presence of multiple human strengths, developmental maturity, dominance of positive emotions, socio-emotional intelligence, subjective well-being and resilience“ (Vaillant 2012). Future posttraumatic personal growth and resilience research is enormously challenging and promising.

Conclusion

The fact that PTSD is included in DSM-IV-TR and ICD-10 with clearly defined diagnostic criteria may lull us easily into false perception that everything is clear with PTSD as a specific psychopathological and diagnostic entity. Reading the literature we are confronted with three issues, one explicit, about the „facts“, and the other implicit, about the „false facts“ or „pseudofacts“ and the third epistemological about the „metafacts“ of

PTSD. That is why in this issue of *Psychiatria Danubina* we tried to cover some relevant aspects of PTSD from genetic markers to multiperspective models with hope that it would be useful to a broad range of readers.

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