

Don't Throw Out the Baby With the Bathwater (PTSD Is Not Overdiagnosed)

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In the aftermath of the terrorist attacks on the World Trade Center, some media “experts” predicted that up to 1 out of 5 New Yorkers would suffer from full-blown posttraumatic stress disorder (PTSD). In fact, 2 months after the attacks, among a random sample of 1008 adults living in Manhattan, only 7.5% reported symptoms consistent with a diagnosis of acute PTSD.¹ It is relatively easy these days to find instances among the media and the general public where the concept of psychological trauma is overapplied or misrepresented, giving the impression that PTSD must be rampant and therefore overdiagnosed. Despite the popular use of this term, actual prevalence rates demonstrate that PTSD is not overdiagnosed by those whose job it is to diagnose: the epidemiologists and the mental health professionals. If we consider the evolution in the field of trauma research, there are at least 2 major tendencies: on the one hand, the criteria for diagnosing PTSD have become stricter, while, on the other hand, our ability to detect and correctly assess trauma exposure and PTSD has improved, thereby leading to the identification of new, previously undiagnosed cases. The net result of these 2 tendencies is a remarkably stable rate of PTSD in the epidemiologic surveys of the last decade.

Changes in the Diagnostic Criteria of PTSD

The diagnostic criteria of PTSD have undergone many minor changes since they were introduced in the DSM-III (1980). With the publication of DSM-IV (1994), however, a major change was introduced: the definition of what constitutes a traumatic event shifted from a nomothetic to an idiographic one. From that point on, trauma was no longer defined as an objective event but rather as a life-threatening experience that must, in addition, be appraised by the exposed individual with fear, helplessness, or horror. In the absence of such distress, the event was no longer considered traumatic. In many instances, this change dramatically reduced the number of individuals typically considered as having been exposed to a traumatic event.² In addition, the emergence of the social impairment criterion in the DSM-IV (for all mental disorders) decreased the prevalence rate of PTSD up to 24%, according to a recent study.³

Changes in Epidemiologic Survey Methodology

Although the criteria for diagnosing PTSD have evolved toward being more restrictive, our ability to detect and assess trauma has also improved. For instance, in epidemiologic surveys, lists of potentially qualifying events (and the use of explicit definitions, as in the case of sexual abuse) to prime the memory of the participants are now routinely used, something which was not done in the earlier surveys. As a result of this and other methodological improvements, the rates of PTSD did go up. For instance, in 1987 Helzer et al⁴ found in the Epidemiological Catchment Area study a lifetime rate of PTSD of only 1%. Since then, however, large surveys conducted in the United States have found higher but remarkably similar rates of lifetime PTSD: 7.5% and 6.6% in 2 representative samples of the US population^{5,6} and a conditional risk of 9.1% among the exposed in a sample of young urban US adults.⁷ This stabilization of the PTSD rate in carefully designed epidemiologic surveys argues strongly against the idea that PTSD is overdiagnosed.

Another example of the crucial role played by the survey methodology comes from Thompson et al.⁸ In a reexamination of the National Vietnam Veterans Readjustment Study (NVVRS) and the Vietnam Experience Study (VES), Thompson et al managed to reconcile the 2 studies' quite different prevalence rates (15.2% and 2.2%, respectively) by applying each study's definitions related to diagnosis. Since the NVVRS made use of multiple standardized and well-validated diagnostic instruments and used many more PTSD symptom probes than the VES, the former's statistical results were deemed more reliable. In fact, one could say that studies such as the VES as well as the epidemiologic study of Helzer et al suggest that, in the 1980s, PTSD was largely underdiagnosed. This tendency, fortunately, has since been corrected.

PTSD and the Issue of Comorbidity

The early epidemiologic studies illustrate how easy it is to miss a diagnosis of PTSD if one does not have the right investigative tools. There are several other reasons why it remains easy to miss a diagnosis of PTSD. One of them is comorbidity;

84% of individuals with PTSD meet criteria for at least one other psychiatric disorder.⁶ Comorbid disorders such as major depression, alcohol abuse, substance abuse, specific phobias, panic disorder, schizophrenia, and antisocial and borderline personality disorder may all be diagnosed first, thereby relegating the individual's trauma history (and possible PTSD) to the background. In fact, now that PTSD is an established disorder, the contribution of trauma exposure to the development of mental health problems other than PTSD is beginning to receive more attention (see Shaler et al⁹). PTSD may similarly be underdiagnosed in individuals suffering from medical conditions such as traumatic brain injury, cancer, chronic pain, fibromyalgia, and paralysis. Greater awareness with respect to the diagnosis of PTSD has led, and will in the future lead, to the detection of cases that were previously going unnoticed.

PTSD Remains Underdiagnosed in Several Subgroups

PTSD is still underdiagnosed in several important subgroups. In Western countries, it is well known that men tend to underreport psychiatric symptoms, relative to women.¹⁰ Likewise, cases have been reported of intake interviews of young children resulting in no diagnosis of PTSD unless corroborating evidence was taken from parents or other adults.¹¹ Street prostitutes, who typically report high rates of lifetime trauma exposure and PTSD,¹² rarely come to the attention of mental health professionals, and may not be included in epidemiologic surveys. Other such examples include battered women in shelters, immigrants coming from countries with oppressive regimes, First Nations people living on Reserves, the homeless, and prison inmates. Cultural norms may also in some instances restrict diagnosis. For example, in Asians the symptoms of PTSD are primarily expressed as somatization, and patients will often present to their general practitioner with physical complaints.¹³

The Issue of Malingering

In closing, a word needs to be said about malingering. All mental disorders are prone to malingering when there are secondary gains, and PTSD is no exception. However, in the case of PTSD, the reverse is also true. Stigma is perhaps most prevalent in the very occupations where PTSD is most likely, such as among law enforcement and corrections officers, emergency workers, firefighters, and soldiers. In many societies, there is also limited support for reporting crime-related trauma or "shameful" sexual trauma, which carry another form of stigma.

Conclusion

In summary, we have argued that the official diagnostic criteria for PTSD have, in fact, become stricter over the last 25 years; that the moderate increase in the rate of PTSD cases observed in the late 1990s most likely reflects our improved capacity to detect trauma and our increasing awareness of the role played by trauma in the etiology of mental health

problems, rather than a pandemic of new PTSD cases; that several subgroups exist whose PTSD is still underrecognized; and that prevailing social stigma probably still leads to the underestimation of the true rate of PTSD in our societies.

Although frivolous claims of PTSD will likely continue to occur from time to time, the public debate and increased awareness about the hidden human and financial costs of traumatogenic events such as warfare, rape, and child abuse—to name just a few—must continue for the good of society. From a scientific perspective, PTSD probably represents one of the best models in psychiatry of a gene × environment interaction. Does this renewed interest for the role of trauma exposure in the etiology of mental disorders represent the advent of a truly biopsychosocial psychiatry? Time will tell . . .

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