From the Editor's desk

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THIS MONTH'S ISSUE: THE DEVALUATION OF PTSD

This month's issue is a highly significant one. Editors should be neutral, but also honest, and I should come clean about my views on post-traumatic stress disorder, now almost always abbreviated to its acronym. For researchers it has been a boon but for clinicians (at least in my kind of practice) an interference in care. No one doubts the existence of extreme and unpleasant reactions to severe stress but reifying them to special diagnostic status has always worried me. This issue does not change my views. As Wessely in his stimulating lecture (pp. 459–466) has pointed out, the diagnosis has been inflated, and inflation leads to devaluation. So the collective message of the papers in this issue suggests that we have been damaged by the growth of PTSD as a prominent and fashionable accoutrement of our risk-conscious age. Frueh and his colleagues (pp. 467–472) show that 94 out of 100 Vietnam veterans were diagnosed as having PTSD at a highly respected special clinic in which an exhaustive assessment was made of each individual, yet 59 of these had no combat exposure and 5 had never been in Vietnam. Mol and her colleagues (pp. 494–499) add to the diagnostic doubt by showing that life events lead to higher PTSD scores than traumatic events. When trauma is expected and its risk anticipated, as when well-prepared soldiers go to war, mental health is not adversely affected, and Hacker Hughes *et al* (pp. 536–537) show that it is actually improved by active service. Those evacuated from the theatre of war, at least in modern-day conflict, are mainly suffering not from combat stress (Turner *et al*, pp. 476–479) but from conditions that can follow any major life event. When risk ends for those trained in risky ventures there is a sense of anti-climax, and for those who are vulnerable and leave the armed services it is not surprising that the natural reaction to loss – depression – is the most common consequence (Iversen *et al*, pp. 480–486).

So what do we learn from these revelations? First, at a personal level, I feel reinforced in the clause I have inserted into my will that if I lose my life in the course of my assertive outreach work, I do not want a public inquiry; the risk goes with the territory. Second, we must do something to reform the definition of a diagnosis that so often is a grotesque parody of its four emotive words. PTSD is so frequently PESD, or post-event stress disorder, and then really satisfies the requirements for the diagnosis of adjustment disorder, a diagnosis that has almost been forgotten (Casey *et al*, 2001) as attention has been diverted to its rapacious bedfellow. Third, the medico-legal status of the diagnosis needs to be reviewed. PTSD is the US dollar in the money market; it trumps almost all others and so people (both patients and their physicians) are keen to exchange their less attractive diagnostic currencies for one that yields more, even if it sometimes means less. Lastly, we need urgently some independent test of veracity for the diagnosis, either biological or psychological, assuming one exists. As knowledge of mental illness increases, the factitious presentation of all illness for purposes of gain is increasing, and even schizophrenia and other psychoses are not immune (Tyrer *et al*, 2001), so the danger of real disorders being discredited by phoney presentations is increasing. In reporting both personal disasters (Jones & Craddock, pp. 453–454) and their major equivalents such as the two reported by Carol North and colleagues (pp. 487–493) and, very shortly, in those following the tsunami tragedy, we do not want the genuine suffering of so many people to be devalued by doubt.

RANDOMISED TRIALS – WHAT MIGHT HAVE BEEN

In a recent review of his life's work (Cook, 2004), the doyen of British epidemiologists, Sir Richard Doll, described how 40 years ago he tried to persuade the Department of Health to fund a randomised trial to test the value of mental hospital admission *v.* community care, but, even for Sir Richard, they had no money. What a pity that nobody listened, or responded constructively, to Sir Richard's suggestion. Just how many of the 102 980 admissions to psychiatric hospitals in England in the financial year 1999/2000 were really necessary and does the fact that the North-West region has a 41% higher rate of admission than the Eastern one (Thompson *et al*, 2004) indicate better or worse care? We will never know as it is too late to interfere with the juggernaut of policy. There are so many other trials that could also have helped us today; from the long-term effects of diet on mental health in children to the custodial or community management of mentally disordered offenders, and as a consequence we have to scratch about in the backyards of research looking for what is essentially second-hand evidence. In the distant past, when the mental hygiene movement was at its peak, we might have also conducted trials into the diversion of those who have (somatoform) conditions such as irritable bowel syndrome into psychiatrically or medically oriented care; from the results of the study by Creed *et al* (pp. 507–515) it is interesting to speculate what might have been the outcome.

Casey, P., Dowrick, C. & Wilkinson, G. (2001) Adjustment disorders: fault line in the psychiatric glossary. *British Journal of Psychiatry*, **179**, 479–481.

Cook, C. (2004) Oral history: Sir Richard Doll. *Journal of Public Health*, **26**, 327–336.

Thompson, A., Shaw, M., Harrison, G., *et al* (2004) Patterns of hospital admission for adult psychiatric illness in England: analysis of Hospital Episode Statistics data. *British Journal of Psychiatry*, **185**, 334–341.

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