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Editorial

The dangers of inflation: memories of trauma and post-traumatic stress disorder†

Neil Greenberg and Simon Wessely

Summary
People who suffer from post-traumatic stress disorder (PTSD) are likely to find that their quality of life is substantially impaired. However, unlike other diagnoses, in order for clinicians to make a diagnosis of PTSD people have to be able to accurately recall the details of a traumatic incident. Yet recent evidence suggests that recall of such incidents is often unreliable. Clinicians should therefore exercise caution to avoid making inaccurate diagnoses.

Declaration of interest
N.G. is a full-time active member of the Royal Navy.

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People are no strangers to adversity – an inhabitant of the USA has a lifetime risk of being exposed to a seriously traumatic event of about 40%.[1] Although only a minority of those exposed to such an event will go on to develop post-traumatic stress disorder (PTSD),[1] as with all the major psychiatric disorders those who suffer with PTSD are less effective at work,[2] have poorer relationships[3] and are substantially limited in both carrying out and gaining enjoyment from their activities of daily living.[4] Furthermore a substantial proportion of those who suffer from PTSD have comorbidity, most commonly affective disorders or substance misuse.[5]

In order to develop PTSD an individual needs to be exposed to a traumatic event or series of events. According to commonly used diagnostic criteria such events should involve 'actual or threatened death or serious injury' (DSM–IV)[6] or be of 'an exceptionally threatening or catastrophic nature' (ICD–10).[7] Furthermore, the reaction to the event should be likely to 'cause pervasive distress in almost anyone' (ICD–10) or involve 'intense helplessness, horror or fear' (DSM–IV). So when a clinician is considering making a diagnosis of PTSD, and assuming that he or she witnessed neither the event itself nor the individual's reaction to it, they must rely on the person's narrative of the trauma and recollection of how they reacted at the time. The latter is particularly important since even if the clinician is familiar from other sources with accounts of the trauma, that information will be of meagre assistance in determining the nature of any given individual's involvement in the event and whether their reactions were sufficiently intense to a degree that would satisfy the criteria for a diagnosis of PTSD.

The recall of traumatic stress

Several groups have used longitudinal designs to examine the reliability of recall of traumatic exposures.[8,9] However, the paper by Heir and colleagues[10] portrays a powerful message advising caution in uncritically accepting retrospective reports of the emotional impact of a trauma. They studied a sample of 532 Norwegians all of whom had been involved in the 2004 Tsunami. Participants were first studied 6 months after the disaster and then again 2 years later and the researchers found that, over time, the reporting of the intensity of threat increased substantially. This finding was not influenced by personality, demographic factors or the magnitude of the traumatic exposure.

The timings at which the investigators administered their questionnaires is of interest as it adds to the ongoing debate about whether delayed-onset PTSD really is a valid construct.[11,12] The finding, reported by Heir *et al*, that the PTSD symptom severity of individuals who were found to have recall amplification appeared to remain the same over time was in stark contrast to those without recall amplification whose symptoms improved.[10] This finding may suggest that apparent delayed-onset PTSD is really delayed presentation, which may in part be as a result of the amplification of the perceived severity of the incident. It may also help to explain why delayed PTSD can be so difficult to treat – perhaps one is treating the wrong condition. This may well be financially costly as well wasting clinician's and patient's time.

The validity of PTSD as a diagnosis

Heir and colleagues conclude that their findings may call into question the diagnostic validity of PTSD. Their results deserve careful scrutiny and discussion, and must neither be ignored nor anathemised – both fates that are possible in the current charged atmosphere of the politics of PTSD. A more balanced reaction is to accept that when 'taking a history' from those who have been exposed to trauma, we do so with all the tools that professional historians bring to the task. Oral history and testimony are vitally important but few, if any, historians would argue that both provide all that one needs to recreate the past; oral testimony is, like all historical sources, subject to bias.

Culturally we are, at least in many Western countries, going through an 'age of trauma'. A generation that was schooled in reticence and private grief has been replaced by one in which emotional expression is increasingly valued and indeed encouraged. At the same time, and as progressive editions of our diagnostic manuals confirm, the boundaries of what

†See pp. 510–514, this issue.

constitutes trauma have been gradually shifting. It is possible that this subtle inflation of trauma is also reflected in the increase in reported traumatic memories demonstrated by Heir and colleagues.

Conclusions

The argument as to whether or not adult traumatic experiences can cause discrete psychiatric disorder is over – they can and do. But clinicians must pay more attention to the numerous influences that affect how someone responds to a potentially traumatic event and their often delayed appearance in our clinic. Otherwise, there is a danger of both inappropriate usage of diagnostic labels and unnecessary, and quite probably ineffective, psychiatric interventions for those that do not need them.

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