Posttraumatic Stress Disorder: Issues and Controversies

edited by Gerald M. Rosen; New York, John Wiley & Sons, 2004, 268 pages, $45 softcover

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Is posttraumatic stress disorder (PTSD) an illness that arises after horrific and life-threatening events? Or is it a label that medicalizes human suffering and brings with it more problems than it solves? These questions are enthusiastically and thoughtfully tackled in *Posttraumatic Stress Disorder: Issues and Controversies.* The very fact that mainstream academics are undertaking such iconoclastic inquiry is a welcome sign that the tide may be about to turn.

That tide is the near-quarter-century thrall of clinicians and researchers to the notion that PTSD is a mental illness as natural as, say, schizophrenia—a biologically driven disease with stable characteristics that are fixed across cultures. As the book's editor, Gerald M. Rosen, a clinical professor of psychology at the University of Washington, puts it, this "is the rare moment when most every assumption and theoretical underpinning of a psychiatric disorder comes under attack or is found to lack empirical support."

Over the course of 12 chapters, this book meticulously examines the major assumptions and underpinnings associated with PTSD. The authors ask, for example, whether PTSD is a unique disorder or an amalgam of already known symptoms associated with depression and anxiety. What is the reliability of the instruments used to assess it? What is the nature of traumatic memory? The book opens with a chapter by Richard McNally—author of the excellent *Remembering Trauma* (1)—that emphasizes the importance of how we define a traumatic event: "The prevalence of the disorder, characterization of its psychobiological correlates, its assessment and treatment, all depend on how we define what counts as trauma," he writes. Now that the *DSM* defines a traumatic stressor as the experience of learning about tragedies that happen to others as long as the response involved intense fear, helplessness, or horror, we have opened up the floodgates for personal injury lawyers. The current version—a symptom of "conceptual bracket creep," as McNally calls it—has diluted the meaning of PTSD such that it becomes circular—that is, a trauma is anything that traumatizes. In the end, PTSD becomes a sprawling catchphrase that undermines the validity of diagnosis, treatment, and research. The latter, especially, depends on homogeneous study samples if it is to reveal, among other things, meaningful information about response to treatments and the biological correlates of PTSD.

These concerns anticipate the next chapter that discusses vulnerability to PTSD. Marilyn Bowman of Simon Fraser University in Burnaby, Canada, and Rachel Yehuda of Mount Sinai School of Medicine in New York show that the characteristics of the individual rather than the event are the best predictors of posttraumatic morbidity. This distinction is important, because it upends the common misconception that PTSD is a normal response to disaster and that everyone exposed to a catastrophic event is at risk of developing PTSD (the guiding philosophy of the trauma counseling industry—whose ministrations are deservedly discredited in a chapter by Richard Bryant of the University of New South Wales in Australia). Bowman and Yehuda provide a review of the literature documenting the infrequency with which trauma victims develop PTSD and summarize the data on risk factors that operate before, during, and after extreme events. They discuss the after-event cognitions that appear to influence the development of PTSD—namely, appraisal by the individual that the stressor he or she encountered is harmful, appraisal that the individual is vulnerable, attempts to assign meaning to the event, and beliefs about the degree of control he or she has.

A historian (Ben Shephard) and an anthropologist (Allan Young of McGill University in Montreal, Canada) offer, respectively, the military and intellectual historical contexts of PTSD. Both underscore the powerful role of suggestion in the manifestation of symptoms and the extent to which those symptoms can render individuals dysfunctional. Indeed, the central tension in managing individuals who have been exposed to extreme events, Shephard notes, is how to discourage a group of people who were exposed to a crisis from developing psychiatric problems while simultaneously providing competently for those who are overwhelmed by the crisis. He asks, "Will psychiatrists have the sense to realize that by medicalizing the human response to stressful situations they have created a culture of trauma and thus undermined the general capacity to risk trauma?" Shephard's context is the battlefield, but his observations apply astutely to the mental health maneuvers employed after September 11, 2001, when an epidemic of PTSD was predicted and hundreds of millions of dollars were made available for crisis counseling. And in what seemed like a near parody of low expectations of people's ability to cope, a psychiatric service in New York City offered counseling to Republican delegates who might be "stressed" by the police presence and terrorist threats at the 2004 convention this past August. Granted, we do not have hard data on whether these messages lead to iatrogenic stress reactions. However, observations from previous wars, from present-day Department of Veterans Affairs hospitals, and, not least, the repressed-memory fiasco suggest that the phenomenon is indeed real.

These authors and others in the book (James Herbert of Drexel University and Mark Sageman of the University of Pennsylvania in Philadel-

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phia) point out the stark contrast between the way we manage trauma patients today and the approach of the British Army in World Wars I and II. Specifically, those armies discovered that they could reduce the numbers of psychiatric casualties if they did not name a syndrome (the term "shell shock" was banned by the British Army in 1917), did not publicize the syndrome's symptoms, and did not reward people (with pensions) for displaying these symptoms. Herbert and Sageman write, "This emphasis has been largely forgotten in modern approaches to treating posttraumatic stress disorder."

Other first-rate chapters review the literature on the treatment of PTSD, the validity of assessment methods, and the nature of traumatic memory—asking whether it qualitatively different from other memory. Psychologists Chris Frueh and Gerald Rosen are lead authors of chapters devoted to discussions of the validity of the PTSD database. Their demonstrations of how unreliable self-report can be—as the result of both inevitable memory distortion and outright malingering—should make us fear for the integrity of the scientific literature on PTSD, especially the literature based on the self-report of Vietnam veterans.

The final chapter is an eye-opening look at the significance of PTSD in other cultures. British psychiatrist Derek Summerfield writes persuasively that brutalized and deprived populations do not benefit from the Western approach to trauma that has often been imposed on them. That approach, Summerfield says, "[assumes] that the experience of war routinely generates not just suffering or misery but 'posttraumatic stress,' a pathological condition affecting large numbers of those exposed and who need attention for this; there is basically a universal human response to such events; Western mental health technologies are universally valid; that victims must 'work through' their experiences [and] that timely intervention can avert later mental disorders."

Although the book is skeptical of accepted wisdom and resolute in examining controversies from seemingly every conceivable angle, it never loses sight of the fact that human suffering is real and abundant and that traumatic events can surely lead to pathological states that can benefit from treatment.

As Rosen rightly says, "For better or worse, PTSD has changed our vocabulary and shaped our views on human resilience and coping in the face of adversity. It is time to step back and consider . . . where the diagnosis is taking us." Rosen's book is a deeply thoughtful and learned contemplation of where we have been taken, and as such I recommend it as required reading for anyone with a special interest in trauma and PTSD. Meanwhile, generalists will profit too, given that PTSD has become the diagnosis du jour and trauma is now implicated as the root of so many other psychiatric conditions. Also, with the growing—and questionable—trend in state mental health systems to create special trauma initiatives and not least the task of diagnosing and treating distress among veterans of the Iraq and Afghanistan conflicts, the lessons of this perceptive book will radiate far beyond the pool of trauma experts and researchers.

Reference

1. McNally RJ: Remembering Trauma. Cambridge, Mass, Harvard University Press, 2003

Managing Chronic Illness Using the Four-Phase Treatment Approach: A Mental Health Professional's Guide to Helping Chronically Ill People

by Patricia A. Fennell; New York, Wiley, 2003, 439 pages, $58

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Taking care of individuals with chronic illness is serious work that demands a thoughtful, organized, and dedicated approach. Patricia A. Fennell, chief executive officer of Albany Health Management, Inc., New York, has extensive clinical experience in managing such individuals and, through her work and publications, is regarded as an expert in the field. Her expertise is evident through the insights she shares with us about chronic illnesses and their heterogeneity in *Managing Chronic Illness Using the Four-Phase Treatment Approach: A Mental Health Professional's Guide to Helping Chronically Ill People.*

Fennell proposes a model for management of chronic illnesses such as chronic fatigue syndrome and multiple sclerosis by using a systems approach that comprehensively integrates the biological, psychological, sociocultural, and spiritual dimensions to determine the common elements underlying their manifestation and management. This model considers that a person's body, mind, family, friends, clinicians, colleagues, and community are essential contributors to the total system. Changes that occur in one part of the system affect all other parts. The four phases experienced by people with chronic illness include crisis, stabilization, resolution, and integration. Although these phases are sequential, the model recognizes that individuals may move backward and forward and sometimes exhibit signs of being in more than one phase simultaneously. The treatment approach assumes that patients who successfully navigate the four phases will achieve integration rather then cure. Fennell writes, "most of the assumptions of this model are neither novel nor original."

The first phase, described as crisis, is when the acuity of the illness causes the person to seek professional in-

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