Post-Traumatic Stress Disorder or Post-Traumatic Stress Injury: What's in a name?

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Abstract

Background: Post-Traumatic Stress Disorder (PTSD) is a trauma-induced condition that is associated with high healthcare usage and costs, as well as long-term disability. Enabling those affected to seek diagnosis and treatment and removing barriers to care is, therefore, a significant priority.

Results: In the last few years, an argument has been made that changing the name of the condition to Post-Traumatic Stress Injury (PTSI), and hence removing the word 'disorder', may remove some barriers to seeking diagnosis and treatment. This paper describes the historical, scientific and medical basis for the use of the existing term, and argues that there is a lack of evidence that altering the name would have an appreciable benefit for affected individuals.

Conclusion: Serving and ex-serving ADF members and their families affected by PTSD would be better served by holistic approaches to improve education and awareness, encouraging help seeking as early as possible and further high-quality research to improve evidence-based treatment and rehabilitation services that are recovery focused.

Key words: post-traumatic stress disorder; post-traumatic stress injury

Conflicts of Interest: Dr Wallace is employed by BUPA and contracted to the ADF. Mrs Jallat is a member of the Australian Public Service. COL Jetly is a serving member of the Canadian Armed Forces.

Introduction

Post-Traumatic Stress Disorder (PTSD) is a trauma-induced condition that is associated with high healthcare usage and costs, as well as long-term disability.[1] Its 12-month prevalence rate among personnel recently transitioned from the Australian Defence Force (ADF) was estimated in 2015 at 17.7%, almost double that of the Regular ADF in 2010 (8.3%).[2] Enabling those affected to seek diagnosis and treatment and removing barriers to care is a significant priority.

In the last few years, an argument has been made that changing the name of the condition to Post-Traumatic Stress Injury (PTSI) may remove some barriers to seeking help for affected individuals. Those in favour of the change argue that the word 'disorder' is stigmatising—no one wants a 'disorder,' let alone to seek treatment for one. A secondary argument has been that the word 'injury' provides a better description in the context of trauma causing a physical injury to brain physiology.

Based upon a paper prepared to assist members of the Prime Ministerial Advisory Council on Veterans' Mental Health in their recent consideration of proposals for use of the name PTSI instead of PTSD, this article provides a brief history of the origins of PTSD diagnosis and describes the debate about the proposed name change. It argues that there is no evidence that the word 'disorder' does in fact stigmatise, nor that the word 'injury' necessarily provides the required solution to removing barriers to seeking diagnosis and treatment for those with PTSD.

History of the term PTSD

PTSD is a medical condition with a defined set of diagnostic criteria described in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5).*[3] First introduced in *DSM-III* in 1980, the diagnosis was the result of advocacy by groups representing traumatised individuals, in particular Vietnam veterans. Shephard[4] described how PTSD was politically inspired from the outset; originating as

'Post-Vietnam Syndrome,' as described by veterans organisations and sympathetic psychiatrists, but later changed to PTSD, when research from Holocaust and Hiroshima survivors was added.

Prior to DSM-III, post-traumatic illness was conspicuous among medical conditions for the many names given through history. First described in the nineteenth century, these conditions included railway spine,[5] nostalgia, irritable heart[6] and disordered action of the heart in the Boer War.[7] During World War II, shell shock, not yet diagnosed, nervous and neurasthenia were used.[4] World War II led to diagnoses such as war neurosis, combat fatigue, psychoneurosis and non-ulcer dyspepsia.[7] This plethora of diagnoses surely impeded understanding of post-traumatic conditions, delayed the development of treatment and contributed to barriers to care and patient stigma; arguably providing historical evidence of the negative impact of changing diagnostic terms.

The inclusion of PTSD in *DSM-III* was thus an important positive step, since it clearly distinguished the condition from other mental disorders, such as generalised anxiety disorder (GAD), noted that it required tailored treatment and provided a common language for clinicians, researchers, educators and consumers to enable comparison of populations and treatments around the world.

Origins of the name change debate

In 2011, as the rate of suicide rose alarmingly in the US Army, LTGEN Peter Chiarelli, then Deputy Chief of Staff of the US Army, wrote to the American Psychiatric Association (APA), the publishers and owners of the *Diagnostic and Statistical Manual of Mental Disorders*, asking them to change the name of Post-Traumatic Stress *Disorder* to Post-Traumatic Stress *Injury*. He had apparently begun using the term 'Post-Traumatic Stress' to address the problem of stigma and barriers to care; but after discussions with a number of psychiatrists, he hit upon the term Post-Traumatic Stress *Injury*. His advocacy for the change opened up a significant debate in the US. Despite some support from US psychiatrists, the APA decided in 2012 not to change the name, retaining the term Post-Traumatic Stress *Disorder*, but with amended diagnostic criteria, in the *DSM-5*3 in 2013.

Nevertheless, debate continues, and appears to be coordinated by a US website, *Post-Traumatic Stress Injury*.[8] Readers of the website are encouraged to send emails to the APA *DSM-5* committee to lobby respectfully for the suggested change in the name, with the website arguing,

'The 'D' in PTSD, the word, 'disorder,' discourages some from seeking care, from revealing their condition and from feeling a sense of honor, when their PTSD is just as honorable as any physical injury. When an injury is earned in battle, awards are given. There is no Purple Heart for PTSD. While the APA uses the term 'disorder' for most diagnoses, there are many diagnoses without that word: Anorexia, Bulimia, Parasomnia, Social Phobia to name a few'.

However, anorexia nervosa and bulimia nervosa are both classed as eating disorders, parasomnias are sleep-wake disorders and social phobia has been renamed social anxiety disorder. Interestingly, no case has been made to change GAD, major depressive disorder, adjustment disorder and substance use disorders, some of which have been reported as being more common outcomes of trauma than PTSD.[9]

In Australia, former Chief of Army turned academic, LTGEN Peter Leahy (Retd), spoke publicly in support of the suggested name change in 2012[10] and 2013.[11] While a quick examination of publicly accessible social media showed a small number of sympathetic comments supporting the change, the authors were not aware of any organised campaign or movement for change within Australia.

What is a 'mental disorder'?

Part of what made the *DSM-III* so practical and widely accepted was its inclusion of the concept of 'mental disorder.' Fisher and Schell[12] described how this concept has been retained in subsequent editions and in *DSM-5* was defined as per Box One, with the World Health Organization definition of 'injury' for comparison.

Box One: Comparison of definitions of 'mental disorder' and 'injury'

Definition of 'mental disorder' (DSM-5)[3]	Definition of 'injury' (WHO)[9]
'A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning … usually associated with significant distress or disability in social, occupational, or other important activities'.	'A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance'.

3 *Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition. Arlington: American Psychiatric Publishing: American Psychiatric Association; 2013.*

9 *World Health Organisation. International Classification of External Causes of Injuries, Version 1.2; 2004.*

Some proponents of PTSI argue that PTSD is a biological trauma,[13] as there is evidence it responds to biological treatment such as Stellate Ganglion Blocks.[14] They argue that the affected person is not 'disordered,' but instead that brain function is 'injured.' The *DSM-5* definition of mental disorder, however, does point to *biological* dysfunction, which is arguably a better description of PTSD than 'injury', which implies a wound or physical damage. Indeed, Fisher and Schell[5] concluded that the term 'injury' should be reserved for cases where an external physical force is the direct cause of the reaction. Furthermore, while a condition may respond to a biological treatment, this does not necessarily mean that the trauma is purely biological in nature.

McFarlane[15] argued that PTSD should be viewed as a systemic illness, recommending the adoption of a staging model[16] that accounts for a sequence of emerging patterns of biological deregulation, psychological symptoms and somatic pathology. There is growing evidence that for some, PTSD takes time to develop[17] and while in a sub-syndromal form has been associated with higher rates of suicidal ideation,[18] alcohol abuse,[19] withdrawal from loved ones,[20] increased anger and aggression,[21] as well as increased usage of health care services and work absences.[20] The *DSM-5* definition of 'disorder' better encompasses the diverse range of sub-syndromal and emerging patterns of dysfunction than the word 'injury,' particularly since injury implies a single point in time when a wound occurred.

Is 'disorder' actually stigmatising?

Stigma is the negative evaluation resulting from a social label[22] and can be attributed internally (i.e. personal beliefs about mental illness or mental health treatment) or externally attributed (i.e. public stigma, the extent to which an individual believes that he or she will be stigmatised by others). 'Concerns about what others think' was identified as an important barrier for seeking treatment in the National Comorbidity Survey.[23] Furthermore, a meta-analysis by Vogt[24] pointed to numerous studies that suggest stigma is a key barrier to treatment-seeking in general. Therefore, it is plausible that fear of PTSD-related stigma may act as a barrier to seeking treatment among affected individuals.

However, following an extensive review, Fisher and Snell[12] concluded:

> *'There is little empirical evidence documenting the nature of PTSD-related stigmatisation specifically or demonstrating negative effects of PTSD-related stigmatisation on treatment utilisation.'*

They were also careful to point out that a better understanding of root causes of potential stigmatisation would be required before drawing conclusions that the term 'disorder' was in fact stigmatising. Furthermore, they argued that there was no known evidence that a psychiatric 'injury' produced less stigma than a psychiatric 'disorder,' and concluded that altering the label without major changes to how the condition is defined, how diagnosed individuals are treated and how the military uses the information about diagnosis and treatment, meant it would be unlikely to generate dramatic changes in treatment-seeking or treatment utilisation.

Fisher and Schell[12] also questioned whether any research had been done among veterans as to whether they want a change in the name. They further argued that PTSI may give the erroneous impression that the condition is determined only by discrete events from the past, and not as part of a continuing pathological process, which as noted earlier has been supported by recent research[16]. Additionally, recent Australian research[25] indicated that even when current serving and ex-serving ADF

members held high levels of stigma-related beliefs, the vast majority still engaged in mental health care.

What has been tried or suggested?

Members of the Canadian Armed Forces (CAF) were exposed to operational stressors in the 1990s of a frequency and intensity far greater than in recent memory. Operations in Rwanda, Somalia and the former Yugoslavia took a toll in the form of psychological casualties. Several high-profile enquiries recommended a change in the way Canada, a country that did not share the Vietnam experience with its allies, approached PTSD. It was decided to enhance clinical expertise and capacity; but there were concerns that stigma and other barriers to care would limit the use of services by those most in need. To address this, a cultural shift was considered necessary.

In 2001, the term 'operational stress injury' (OSI) was coined by Lieutenant Colonel (Retd) Stéphane Grenier, as part of the development of a peer-support program in CAF, known as the Operational Stress Injury Social Support Program (OSISS)[26]. As OSI includes not only PTSD, but also depression, anxiety, mania, dysthymia and bipolar disorder, it is not a clinically accurate term, but one whose 'purpose is to serve the profession of arms'.[27] The OSI concept was designed to reduce stigma, to provide education that PTSD was not the only problem resulting from deployments, and to legitimise psychological difficulties as 'real injuries.'

OSI has been a useful paradigm within the CAF, permitting tangible opportunities for leadership to demonstrate the equal footing of physical and psychological injuries such as awarding the same 'sacrifice medal' for those with OSI and physical injuries such as amputation. Great gains have been made over the years by the CAF in reducing stigma, increasing help seeking and improving capacity; however, it would be inaccurate to attribute all of them to the term OSI. As the introduction of the OSI concept coincided with the implementation of a range of programs, including stigma-reduction campaigns, mental health training and education throughout the military career cycle, high-quality mental health research, a doubling of mental health providers and enhanced clinician training, it is hard to isolate the impact of the change in language to OSI.[3] Finally, the question could also be asked whether those with PTSD from non-operational causes (e.g. military sexual trauma) have conversely felt stigmatised by the term OSI.

Anecdotally it is known that some military leaders have been informally dropping the term 'disorder' and referring to 'Post-Traumatic Stress.' This may have a place in describing a person who does not meet the clinical criteria for PTSD but who is nonetheless experiencing stress following a significant incident (though the DSM does provide suitable alternatives such as 'Acute Stress Disorder or Adjustment Disorder'). PTSD, by contrast, refers to a condition that develops when an individual does not recover spontaneously. The difficulty with calling PTSD 'Post-Traumatic Stress' is that it fails to differentiate between a normal stress response to a significant incident, and a response that continues over a longer time period resulting in significant impairment.

What would happen if the name was changed?

If PTSD was renamed PTSI by the ADF and the Australian Department of Veterans' Affairs (DVA) what would be the likely practical implications? Firstly, mental health personnel would have to be educated about the change. When corresponding with civilian specialists and researchers, the new condition may have to be referred to as 'PTSI (ADF) also known as PTSD (*DSM-5*),' on a transitional basis, to ensure clarity. Creating a new condition may generate anxiety in patients searching for information on the effectiveness of treatments and the likely prognosis of the new malady, so veterans and serving members of the military would also need to be educated about the change. Nevertheless, a name change to PTSI would be unlikely to allow a member with this condition to suddenly be made fit to deploy or permit the removal of restrictions on access to weapons, ammunitions and explosives because of a risk of suicide or harm to others. Furthermore, it would not reduce the ADF's duty of care to members.

Obviously, a great deal of work and expense would be required to allow the ADF and DVA to have its own unique psychiatric condition. Perhaps this could be better spent on population health approaches and mental health promotion initiatives aimed at reducing stigma and encouraging early help seeking; for example, psycho-education programs and community awareness initiatives with greater family engagement. Similar strategies saw a reduction in the rate of suicide in Australia following the introduction of a national prevention strategy in 1999[28] and health promotion programs aimed at reducing smoking and skin cancer have also shown success.

Conclusion

Forty years have passed since advocates campaigned to have PTSD recognised. Veterans played a key role in the deliberations that resulted in the *DSM-III* diagnosis of PTSD. It is now an established and widely accepted condition based upon a wealth of research, including treatment trials, and the name is used globally by mental health clinicians, researchers and the public. The name is also scientifically and medically appropriate, as the generally accepted definition of the word 'disorder' aligns more closely with the aetiology and disease progression than that of 'injury'.

The authors acknowledge that there are barriers to seeking treatment for PTSD and other mental disorders in serving members and veterans,[25] and that removal of these barriers and encouraging affected individuals to seek treatment early is an important goal. However, there is no evidence that changing the name of one condition will reduce stigma, remove barriers to care or strengthen recovery. As van der Kolk[29] observed, 'New terms are invented with every generation in order to overcome the stigma of the previous term. So people don't like psychologically wounded people … Whatever name you give it, sooner or later it would become a derogatory word'.

Given the historical, scientific and medical basis for the use of the existing term, and the lack of evidence that altering the name would have an appreciable benefit for affected individuals, the case for change falls short. If further research indicated that a change would materially reduce barriers to seeking treatment, then such a change may be warranted at that time. Until then, serving and ex-serving ADF members and their families affected by PTSD would be better served by holistic approaches to improve education and awareness, encouraging help seeking as early as possible and further high-quality research to improve evidence-based treatment and rehabilitation services that are recovery focused.

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