

Screening for PTSD

We read with great interest the article by Brewin *et al* (2002). The authors examined the efficiency of the 10-item version of the Trauma Screening Questionnaire (TSQ) in detecting post-traumatic stress disorder (PTSD). In our opinion, the scale design has some limitations which may have a negative influence on its practical application.

First, the TSQ contains five re-experiencing items and five arousal items, but not the avoidance and numbing symptoms. According to DSM-IV diagnostic criteria for PTSD (American Psychiatric Association, 1994), the patient requires the presence of at least one re-experiencing symptom (criterion B), three avoidance symptoms (criterion C), and two arousal symptoms (criterion D). The criterion C is the least frequently met criterion but critically significant to the diagnosis of PTSD (Maes *et al*, 1998). Some trauma survivors, who express most PTSD symptoms, do not fulfil the avoidance criterion and are diagnosed as having 'partial' PTSD. Other briefer screening instruments, such as the four-item SPAN (Meltzer-Brody *et al*, 1999) or the seven-item scale by Breslau *et al* (1999), place much weight on the avoidance and numbing symptoms. Therefore, this specific item composition may influence the efficiency of the TSQ.

Second, the TSQ uses the frequency threshold allied to a 'yes/no' response format. Although comparison of scores derived by frequency and by severity indicated a degree of similarity, the severity dimension might provide better discrimination than the frequency dimension (Meltzer-Brody *et al*, 1999). In our clinical experience, subjects can score the severity variable more accurately than the frequency ones (Chen *et al*, 2001). The item selection and scoring method have greater influence on the efficacy of the rating scale.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: APA.

Breslau, N., Peterson, E. L., Kessler, R. C., et al (1999) Short screening scale for DSM-IV posttraumatic stress disorder. *American Journal of Psychiatry*, **156**, 908–911.

Brewin, C. R., Rose, S., Andrews, B., et al (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, **181**, 158–162.

Chen, C. H., Lin, S. K., Tang, H. S., et al (2001) The Chinese version of the Davidson Trauma Scale: a practice test for validation. *Psychiatry and Clinical Neuroscience*, **55**, 493–499.

Maes, M., Delmeire, L., Schotte, C., et al (1998) Epidemiologic and phenomenological aspects of post-traumatic stress disorder: DSM-III-R diagnosis and diagnostic criteria not validated. *Psychiatry Research*, **81**, 179–193.

Meltzer-Brody, S., Churchill, E. & Davidson, J. R. T. (1999) Derivation of the SPAN, a brief diagnostic screening test for post-traumatic stress disorder. *Psychiatry Research*, **88**, 63–70.

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Author's reply: Drs Lu and Shen claim that our Trauma Screening Questionnaire (TSQ; Brewin *et al*, 2002) is flawed because it omits avoidance and numbing symptoms and asks about symptom frequency using a simple 'yes/no' response format. It is puzzling then that the performance of the TSQ is superior to that of all comparable screening measures, including ones that follow Lu and Shen's recommendations. Their views are clearly contradicted by the data from the two studies we reported. Our reasons for designing the TSQ in the way we did were based on empirical and practical rather than theoretical considerations. In our original article we discussed some general principles for designing successful screening instruments, whereas Lu and Shen's comments seem more relevant to a diagnostic instrument. The two types of measure tend to be administered by different professionals, under different circumstances, and with different aims in mind. It seems to us that, as a screening instrument, what the TSQ gains in simplicity and clarity more than compensates for the absence of symptoms that may be difficult to understand and judgements that may be difficult to make.

Brewin, C. R., Rose, S., Andrews, S., et al (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, **181**, 158–162.

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Transcultural psychiatry

Drs Bhui & Bhugra (2002) address the interesting area of explanatory models for mental distress. They do not, however, justify why we should elicit patients' explanatory models. The notion that members of a

specific cultural group hold similar ideas about illness and that culture can be distilled into a set of specific 'beliefs' is considered outdated and oversimplified by medical anthropologists. Kleinman (1980) points out that explanatory models are idiosyncratic and are justifications for actions rather than causes. Bhui & Bhugra themselves cite Williams & Healy (2001), who point out that it is difficult to distil a single set of causal explanations that might relate to behaviour, diagnosis or adherence to medication treatment.

The assertion by Bhui & Bhugra that shared understanding of illness between patient and healer distinguishes traditional healing systems from Western biomedicine is simply not borne out by the anthropological literature. In many systems of traditional healing, patients have little understanding of how the treatment 'works' and it is the healer who holds highly esoteric knowledge. There is little empirical evidence that eliciting explanatory models improves satisfaction. The one study cited (Callan & Littlewood, 1998) in fact found that 79% of patients with divergent explanatory models (a comparison of the explanatory models of doctors and patients) were satisfied with psychiatric services.

Of course, patients do have cultural understanding of their illness but this may not be very sophisticated and may not directly relate to decisions about treatments. There is a large amount of data from medical anthropological research which suggests that treatment choice is determined primarily by social and political factors rather than by underlying explanatory models (Pelto & Pelto, 1997). Even a study using the Explanatory Model Interview Catalogue (Weiss *et al*, 1992) among leprosy patients suggests that those who held theories of humoral imbalance rather than biomedical theories of infection, sanitation and hygiene had the best biomedical clinic attendance records for leprosy treatment. In terms of treatment outcomes patients may not be interested in how a treatment works (Last, 1981) as long as it does work. The weight of empirical evidence suggests that people are keen to utilise biomedical treatments regardless of their cultural beliefs without giving up traditional explanations of illness. In fact, as my own data (Dein, 2001) suggest, among Asian psychiatric patients, biomedical and traditional models of illness are held concurrently and informants agree that biomedical

treatments help symptoms although they do not treat the underlying cause.

Even if we do elicit our patients' explanatory model, how much will it change the treatment we give them? For instance, consider an African patient who, in terms of an ICD-10 diagnosis, is suffering from a hypomanic episode. He is physically violent. Both he and his family hold that he is possessed by a spirit. Are we to accept their explanatory model and enlist an exorcist? Will we withhold pharmacological treatment because the patient holds an alternative view of his illness?

What is needed is an approach in transcultural psychiatry that looks at not just what people believe but what they actually do in practice. A comprehensive approach involving participant observation, not just the administration of questionnaires to patients, will lead to greater understanding.

Bhui, K. & Bhugra, D. (2002) Explanatory models for mental distress: indications for clinical practice and research. *British Journal of Psychiatry*, **181**, 6–7.

Callan, A. & Littlewood, R. (1998) Patient satisfaction: ethnic origin or explanatory model? *International Journal of Social Psychiatry*, **44**, 1–11.

Dein, S. (2001) The use of traditional healing in South Asian psychiatric patients in the UK: interactions between professional and folk psychiatrists. *Transcultural Psychiatry*, **38**, 245–259.

Kleinman, A. (1980) *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.

Last, M. (1981) The importance of knowing about not knowing. *Social Science and Medicine*, **15**, 387–392.

Pelto, P. J. & Pelto, G. H. (1997) Studying knowledge, culture and behaviour in applied medical anthropology. *Medical Anthropology Quarterly*, **11**, 147–163.

Weiss, M. G., Doongaji, D. R., Siddhartha, S., et al (1992) The Explanatory Model Interview Catalogue (EMIC). Contributions to cross-cultural research methods from a study of leprosy and mental health. *British Journal of Psychiatry*, **160**, 819–830.

Williams, B. & Healy, D. (2001) Perceptions of illness causation among new referrals to a community health team: explanatory model or exploratory map? *Social Science and Medicine*, **53**, 465–476.

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Pathways to care in ADHD

I was interested to read Sayal *et al*'s (2002) article on pathways to care for children at risk of attention-deficit hyperactivity disorder (ADHD). By using Goldberg & Huxley's (1980) pathway to care model I felt that the study oversimplified the complexity of professional input to this group of

children, a point raised by the authors in their discussion. I think it is important, when considering improvements to services for children with ADHD, that the role of education is highlighted.

Teachers, as a profession, are well placed to observe children and are familiar with age-appropriate behaviour. Indeed, Goodman *et al* (2000) found that teachers were more sensitive at identifying children with hyperactivity than were their parents. Although teachers' involvement in the assessment and monitoring of children with ADHD is well established (Dulcan *et al*, 1997), their role in identification is less clear. This is highlighted by the fact that only some child and adolescent mental health services (CAMHS) accept referrals directly from schools. By involving teachers in the identification of children with ADHD, access to children would improve from 74% seen in primary care to nearly 100%. This would significantly improve the sensitivity of any screening measure.

It is essential that CAMHS do not develop services for children in isolation, but instead utilise the skills of other professionals to improve care. If children with ADHD are to have their needs met, it is essential that we start to think outside of the medical model.

Dulcan, M. and the Work Group on Quality Issues, American Academy of Child and Adolescent Psychiatry (1997) Practice parameters for the assessment and treatment of children, adolescents and adults with attention-deficit/hyperactivity disorder. *Journal of American Academy of Child and Adolescent Psychiatry*, **36** (suppl.), 855–1215.

Goldberg, D. & Huxley, P. (1980) *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock.

Goodman, R., Ford, T., Simmons, H., et al (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for psychiatric disorders in a community sample. *British Journal of Psychiatry*, **177**, 534–539.

Sayal, K., Taylor, E., Beecham, J., et al (2002) Pathways to care in children at risk of attention-deficit hyperactivity disorder. *British Journal of Psychiatry*, **181**, 43–48.

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Authors' reply: Dr Cribb's comments are welcomed. Our discussion (Sayal *et al*, 2002) also highlights the potential role of both parents and teachers in making referrals to child and adolescent mental health services (CAMHS). The paper is developing

new methodology and we deliberately posed it on a simplified system, selecting an area where most referrals come from general practitioners (GPs). GPs are also the main referrers to CAMHS nationally and their role in primary care trusts will be of great importance in shaping specialist services. Nevertheless, this is only one component of tier 1 services and 48% of CAMHS referrals come from other sources (Audit Commission, 1999). We plan to widen our programme to examine the role of other sources of referral.

Restricting referrals to particular agencies imposes barriers to access, and the resulting delay in referrals might exacerbate severity or chronicity of problems. Kurtz *et al* (1996) described a service that only accepted GP referrals. It failed to reduce the number of referrals and generated resentment from other agencies. Comparisons of CAMHS with different referral systems will improve knowledge in quantifying the barriers to access to services. This could contribute to assisting the successful implementation of the National Service Framework for Children.

The role of teachers in the pathway to care merits particular comment. Relationship difficulties with teachers are a predictor of referral of hyperactive children to CAMHS (Woodward *et al*, 1997). Our study has demonstrated that selective targeting can lead to particularly high rates (98%) of teacher participation in research. This is likely to reflect their concern about behavioural and emotional difficulties in children. Teachers are a rich potential source of child mental health information for parents. However, in considering referrals from schools, it is imperative that teachers fully discuss their concerns with parents. Parents need to agree to any referral. For hyperactivity, in particular, it needs to be ascertained that the problems are pervasive. Unless this happens, there is a risk that learning difficulties are wrongly identified as hyperactivity. This also highlights the importance of adequately resourced educational psychology services to support schools, and health service input in the training of teachers.

Audit Commission (1999) *Children in Mind. Child and Adolescent Mental Health Services*. London: Audit Commission.

Kurtz, Z., Thornes, R. & Wolkind, S. (1996) *Services for the Mental Health of Children and Young People in England: Assessment of Needs and Unmet Need. Report to the Department of Health*. London: South Thames Regional Health Authority.