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EDITORIAL

Is it necessary a scale to evaluate the posttraumatic psychiatric sequelae?☆

¿Es necesario un baremo de secuelas psíquicas postraumáticas?

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Posttraumatic psychiatric pathology (PPP) has been historically relevant in psychiatry since the 19th century in two different aspects: clinically and for compensation.[1] Clinically, when psychiatric disease appeared in the first railway accidents the terms *railway brain* or *railway spine* were coined, depending on whether the symptoms were mental or spinal. Two origins for these diseases were postulated at the time: one with an organic basis (Oppenheim) and one with a hysterical psychogenesis (Charcot and Page).[2] These symptoms have persisted, although under different names, such as traumatic neurosis, subjective syndrome, war neurosis, etc., and all of them have one thing in common: re-experiencing a traumatic event and the subsequent appearance of psychological and/or physiological symptoms. In the same way, there was another psychological illness that appeared secondarily to the physical one, which, given this precedent, seems easier to categorise. When the international classifications of mental illnesses appeared the diagnoses described above have been placed in different categories.

On the other hand, the development of a system to compensate for accidents is important. This occurred due to the increase in the transport of people and goods throughout the 19th century. In 1861 *The Lancet*[3] stated that railway safety was a medical problem in terms of the prevention of accidents. At the time medical assessment was required to set compensation sums, although sometimes the opinions of medical ''experts'' varied so widely that the sensible opinion of one of them was preferable to the highly scientific opinion of another.[4] Throughout the 20th century and especially the second half of the same, scales were established in different countries to homogenise compensation sums. Although these were imperfect, they had the advantage of obliging doctors to use a common language.[5] For posttraumatic psychiatric symptoms this led to the attempt to prepare scales that have either not lasted over time or are not in general use in different countries such as France, Belgium and Spain, and there was even an attempt at a scale for the European Union.[6–10] The non-existence of scales that have been agreed and maintained over time gives us an idea of the lack of agreement between authors in this field, and there are still few regulated studies of this public health problem.[11]

Prevalence

The long-term psychiatric consequences of a physical or psychological injury are substantial, and they are lead to an important burden of long-term disability. This is all the more important as slight or severe trauma affect millions of people around the world.[12] The prevalence of PPP is estimated

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to stand at from 28% to 31% in the period from 12 to 72 months after trauma,[11,12] which agrees with the estimated figures for traffic accidents in previous studies.[13] Nevertheless, its prevalence seems to be connected with the cause of the trauma.[14] According to official statistics, in 2015 there were 97,756 accidents with victims in Spain, with 124,960 non-hospitalised wounded individuals and 9495 who were hospitalised,[15] as well as 97,012 crimes leading to injuries.[16] This number of victims are the people who may potentially suffer PPP, giving rise to the need to evaluate psychological damage for the purpose of compensation. The problem of scales that was described above therefore emerges. There is currently no scale at a European or national level that has been validated.[17] In Spain the medical scale used to evaluate PPP is the one contained in Law 35/2015, of 22 September, on damages and prejudice caused to individual by traffic accidents. This is so regardless of the nature of the traumatic event.

Current status

Although a new scale was published in 2015[18] with some improvements over the previous one of 2004,[19] it is still, from the viewpoint of PPP, an incomplete element that does not fit with the considerations of international classifications. Nor does it consider the limitations in functionality which arise due to mental disorders, giving rise to disadvantages in comparison with functional limitations that have physical causes. An example is that hysterical hemiplegia scores 1–5 points, while if hemiplegia has an organic cause it scores 71–80 point. Another example is that the highest scoring psychiatric sequela is severe chronic major depressive disorder that ''has to fulfil at least seven criteria of the nine described in the DSM-5 or five of the seven of the CIE-10''; it requires continuous medical or psychological monitoring by a specialist, with specific treatment and hospitalisation in a psychiatric facility: 16–25 points. This sequela is seen as so limiting from a functional point-of-view that the possible need for a third person is included, i.e., the scale itself considers that the patient in question will normally be isolated at home, require supervision and care, and that their personal/family life will be very poor. On the contrary, for an important physical sequela such as the amputation of a leg the loss of functionality is estimated to score 45–50 points. We know that with suitable instruments these individuals are able to enjoy a sufficiently integrated l family, social and work life. There is no reason for this differentiation apart from the origin of the sequelae, either psychiatric or physical, and this medical discrimination is unjustified. The problems which arise from using the new 2015 scale are similar those which we described before in another article on the 2004 scale,[17] and which can be summarised as:

1 *The nomenclature used does not correspond to the terms used in international classifications*. This situation means that the many posttraumatic diseases are condensed under 3 headings: neurotic disorders (reserved exclusively for the disorder caused by posttraumatic stress and other neurotic disorders), permanent mood disorders (chronic major depressive disorder and dysthymic disorder) and making previous disease more severe. It does not include any other diagnoses, and this makes it necessary to use the concept of an ''analogy'', which always leads to difficulties in interpretation. Additionally, a novelty in the new scale is that it moves 2 diagnoses (post-concussion syndrome and organic personality disorder) from the field of Psychiatry to the field of Neurology. Specifically, the international classifications are relevant, given that the scale itself establishes the need to use CIE-10[20] or DSM-5[21] criteria (''For diagnosis the criteria of the DSM-V or the CIE-10 and their corresponding updates must be fulfilled''), so that it thereby fails to comply with what it proposes.
2 The diagnostic criteria of the scale differ from the ones used in international classifications for the conditions it refers to. This occurs with posttraumatic stress disorder or chronic major depressive disorder. We are unaware of the reason for this variation, although it is possible that it is an attempt to be more demanding and restrictive when diagnosing sequelae.
3 Psychiatric sequelae score very low in comparison with physical ones. At the same or even higher levels of functional limitation, psychiatric limitations score lower than physical ones, even when the law states that this is the factor that should be evaluated to score sequelae.
4 There is a tendency towards subjectivity in the evaluation of sequelae as broad ranges of scores are established without any clear criteria for establishing a concrete score. This is the aspect that has been worked on the most in comparison with the previous scale, by applying, as we recommended previously,[17] a number of CIE-10 or DSM-5 criteria to evaluate intensity (slight, moderate and severe). Nevertheless, it is still rather vague. A modern scale should be as scientific and objective as possible, and this is why we proposed using the formula to facilitate objective evaluation.[17]
5 The treatment and follow-up criterion. This indicates the need for treatment and follow-up of posttraumatic stress disorder and chronic major depressive disorder. This treatment and follow-up may be undertaken by psychiatric specialists or (disjunctively) in clinical psychology. This possibility of being treated solely by psychotherapy would go against the current criteria which recommend, above all for moderate or severe conditions, combined psychological and pharmacological treatment.[22]

Thus definitively, after a wait of 11 years, little progress has been made. The new scale still expresses the underlying idea that psychology is not very objective and should therefore have minimum scores. We believe that nothing could be further from the truth. Psychiatry is a science that is able to detect and quantify symptoms. You only have to look for them and distinguish what is essential from simulation. Once this has been done, the causal relationship has to be established with the traumatic event, before placing it in a real and effective scale; psychological sequelae should be treated the same as physical sequelae, and the same functional limitation should have similar scores for sequelae. Due to all of this, and considering that in quantitative terms this is an important problem, and given the major repercussions that the situation we describe has on patients with PPP, as well as its quantitative and qualitative

importance, we believe that a scale should be prepared that corresponds to the reality of psychiatry as it is understood by international classifications. This scale would express functional limitations and their consequences based on their real nature rather than on mere suspicions that lack credibility. This scale would in turn be developed by psychiatric professionals without having to wait for 11 more years to continue with an unjust system that lacks objectivity. PPP have their peculiarities and cannot be guided one hundred percent by the same standards as somatic disease. An example of this is the correction of errors contained in Royal Decree 1971/1999, of 23 December, on the procedure for examining, declaring and grading the degree of disability.[23] As well as correcting certain specific aspects of somatic disease, this also established a new and complete system for evaluating mental disorders only 2 months after the system had been published in the *Official State Bulletin*. We therefore understand the proposal to be possible, necessary and fair.

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