Posttraumatic Stress Disorder: A Hidden Epidemic

By Joseph Zohar, MD

Awareness of posttraumatic stress disorder (PTSD) has dramatically increased with the widespread occurrence and publication of terrorism. PTSD received close attention following the September 11, 2001 attacks on the World Trade Center and the Pentagon. This intense interest in PTSD has led to a dramatic increase in resources devoted to its research and, consequently, to careful examination of some of the myths related to the disorder. For example, it is surprising nowadays to find that, until 1980, PTSD was recognized as a disorder that is not only common with combat-related traumas but also with civilian trauma events such as rape, violent robbery, car accidents, and even myocardial infarction. It is even more surprising when we take into consideration that the lifetime prevalence of PTSD is ~6%.[1]

PTSD is unique among psychiatric disorders. It has a definite point of onset and the symptoms are fully expressed from the beginning. By definition, PTSD starts after being exposed to a traumatic event (where the patient has a subjective feeling that he or she could have died) and, theoretically, there is a "window of opportunity" to intervene. Based on this, the idea of debriefing and forward-looking psychiatry has been proposed.[2] We are quite used to hearing about mental health professionals rushing to the scene of a traumatic event–but what is the outcome of their intervention? Research has suggested that one needs to be quite selective in regard to interventions such as debriefing, because in selected groups (eg, highly anxious) such interventions might actually be associated with a less favorable outcome than no intervention.[3] This finding, along with long-term clinical observations on survival of traumatic events, has raised a question about denial as an effective coping mechanism.

A recent study by Ginzburg and colleagues[4] found that a repressive coping style is actually associated with a decreased risk of developing PTSD following myocardial infarction. Although denial is often considered a maladaptive defense mechanism, it is not clear if it might actually help some trauma survivors to carry on with their lives. Thus, if we consider PTSD a failure to recover, our role as clinicians is to clear away the obstacles to recovery; covering it up with denial might actually be adaptive in some cases.

In addition to the emerging data about the potential consequences of nondiscriminative application of debriefing, an evaluation of the effectiveness of the early administration of benzodiazepines has been put into question. Progressive psychiatry, developed during World War I, suggested the importance of keeping the traumatized soldier in the frontline, claiming that it might decrease the risk of developing PTSD later on. This concept has been adapted and is still used today, although the empirical evidence behind it is limited.[5] Concerns regarding unselected debriefing and early intervention with benzodiazepines and the questions surrounding fundamental changes in risk keeping dysfunctional soldiers on the frontline, calls for a careful re-examination of this myth.

Another myth being explored is the predisposition concept. It becomes increasingly clear that the risk factors are related to the trauma itself (eg, intensity, duration), immediate response to the trauma (eg, dissociation, depression, unremitting stress reaction), and posttraumatic factors (eg, social support, depersonalization). Pretraumatic factors, such as socioeconomic background, are lesser risk factors, although the potential to identify susceptible genes is currently the focus of considerable research.

This issue highlights advances related to brain imaging and neuroendocrinology in the field of PTSD. Studies are beginning to reveal that a maladaptive neurobiological dysregulation leading to psychological dysfunction is associated with this intriguing and poorly understood disorder.

CNS Spectrums published an academic supplement entitled "Posttraumatic Stress Disorder: The Hidden Epidemic of Modern Times"[6] in July 1998. The advances that have been made since then are quite remarkable and point to even more exciting developments in the field in the near future. I hope that this issue serves as a relevant and important update on recognizing and treating PTSD. CNS

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