

**Scott Mendelson, M.D.**

Author of *Beyond Alzheimer's*

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## What Is PTSD?: A Post-Hasan Primer

What's Your Reaction?

After the American Civil War, they called it Soldier's Heart. Veterans of World War I suffered shell shock. In World War II it was battle fatigue. After the Vietnam war, which produced so many sufferers of the condition, it came to be known as Post-Traumatic Stress Disorder, or PTSD. It has recently been realized that traumatic situations having nothing to do with war can precipitate what is essentially the same condition in civilians. Thus, the term post-traumatic stress disorder may be the most appropriate name for this psychiatric disorder.

There is controversy, even among mental health professionals, about what types of trauma can precipitate PTSD. This becomes a critical issue when situations such as the rampage of Army psychiatrist Nidal Hasan raise the question of whether psychiatrists who treat soldiers with PTSD can develop a secondary or vicarious PTSD, and thus be at risk for engaging in violent behaviors. I must note that this concern about violence in sufferers of PTSD is an exaggerated one. Although many veterans are returning from Iraq and Afghanistan with PTSD, the perpetration of homicide by these veterans is no higher than what is seen among non-veterans of that age group. These unfortunate veterans tend to destroy their own lives far more often than they harm others. Nonetheless, the fear is that the sufferer of PTSD will experience a "flashback" and in a state of believing they are back in the traumatic event they might act out violently and uncontrollably against innocent individuals.

I recently wrote in the Huffington Post that Dr. Hasan did not suffer vicarious PTSD. I think the evidence now shows that Hasan's violent behavior arose out of political and religious motives and was not driven by PTSD. Nonetheless, the controversy stimulated by my views was compelling enough to lead me to revisit the question of what PTSD actually is and what types of traumatic situations can cause it.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or DSM-IV, is the bible of diagnosis in psychiatry. According to the DSM-IV, an essential component in the triggering of PTSD is "the direct personal experience of an event that involves actual or threatened death or serious injury; or witnessing of an event that involves death, injury or a threat to another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate". The DSM-IV further states that the person's response to this event must involve "intense fear, helplessness, or horror". Personally, I am skeptical about the last category of factors thought capable of precipitating PTSD. However, while I am willing to accept that learning unexpectedly of a gruesome fate of a member of one's family might trigger PTSD, neither I nor the DSM-IV believes that this carries over to strangers.

The symptoms of PTSD include re-experiencing of the traumatic event in nightmares, intrusive thoughts, "flashbacks" of the event, or in being severely distressed by reminders of the trauma. Another symptom is social withdrawal and avoidance of the crowds, places, and things that might remind one of the traumatic event. There is also a numbing of feelings and a "sense of foreshortened future", in which an individual feels that their life is essentially over. Other primary symptoms of PTSD are hypervigilance, ease to startle, insomnia, irritability, anger, and difficulty concentrating.

The intrusive thoughts, flashbacks, and persistence of the hypervigilant state all point to a condition in which the sufferer is to some extent no longer able to clearly distinguish "here and now" from the "then and there" in which the traumatic event occurred. PTSD involves pathology in brain function that leads to a loss of context in re-experiencing the trauma. This loss of contextualization, the diminished ability to distinguish "here and now" from "then and there", is the sine qua non of PTSD. If there is no horrifying, fearful event, then there can be no intrusion of that event into the present. If Hasan or another psychiatrist developed PTSD from hearing stories of soldiers in combat, what trauma could possibly be intruding into their thoughts? Would it be images of their

office? Would it be the horrible feeling that they are actually back in time, safe and sound in a leather armchair while listening to a soldier talk about his disturbing war experiences? For this reason alone the notion of vicarious PTSD is absurd!

There are many significant psychiatric problems other than PTSD. To say that a form of suffering is not PTSD is not to diminish its importance. For example, constant stress and disillusionment from listening to stories of death and trauma can exacerbate or even cause the serious illness of Major Depression. Nonetheless, there are aspects of PTSD that cannot be generated by common disappointments and stresses of life, nor by the experience of treating a soldier who has suffered severe trauma.

What of those who emphatically state that they suffer PTSD, but do not? It is possible for someone to think that there is something very wrong with their heart and be mistaken about it. Despite what they think, they do not actually have a cardiovascular disease. However, psychiatry is complicated by the fact that if someone thinks there is something wrong with their mind, then, by golly, they are right! Thus, a psychiatrist cannot simply dismiss any patient's statement of feeling traumatized, due to the fact that if the patient believes it then they are in some sense correct. It doesn't matter if this sense of trauma is based on having lived through an airplane crash or merely having suffered being goosed on an elevator.

The question for the discerning psychiatrist is whether or not the individual's subjective, and thus real, sense of trauma is due to PTSD, or if it is better categorized as something such as Major Depression, an anxiety disorder, or a personality disorder in which the response is far more dependent on pre-existing problems in the individual than on the nature and intensity of the allegedly traumatic event. Thus, while it is possible for someone to feel traumatized and claim PTSD from having been served a well-done steak that was ordered rare, I would likely not give the diagnosis of PTSD.

Claims that mental health workers are at risk for PTSD from treating their patients add an unnecessary layer of confusion to the question of how we can best serve our soldiers and veterans. This is particularly dangerous at a time when the military is short of mental health professionals and the need for their service is growing. In view of what we know about the nature and cause of PTSD, I believe the military should concern itself first and foremost with providing an adequate number of well-trained psychiatrists and psychotherapists for our troops suffering the traumas of war, and be less concerned about potential dangers these mental health professionals might face in treating them.

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