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PTSD is "PTSD"

September 19, 2012 by Matthew Friedman, M.D., Ph.D.

Changing the name of PTSD won't eliminate stigma or make sufferers more likely to seek treatment.

[Note: This article represents the opinion of the author alone. It does not, in any way, reflect official policy or opinions of the American Psychiatric Association (APA), the US Department of Veterans Affairs or the Department's National Center for Posttraumatic Stress Disorder (PTSD).]

I don't believe the American Psychiatric Association (APA) should change the name Post-Traumatic Stress Disorder (PTSD) to Posttraumatic Stress Injury (PTSI) because I don't believe that such a change will make a significant difference with regard to stigma or make sufferers more likely to seek treatment. I further believe that Canada's military has come up with the right solution: classification of post-traumatic stress as an Operational Stress Injury (OSI). This policy effectively addresses any stigma-related problems without changing the PTSD diagnostic label. In other words, we can have it both ways: keep the PTSD diagnostic term and have it regarded as an injury.

Why does it matter? First, let's consider the term "injury," which is a sufficient description for many purposes. But if I'm the clinician who is asked to treat an "arm injury," I must know more. Is it a bone fracture, a puncture wound, a serious abrasion or a scratch? If it's a fracture, what bone was broken? Is it a compound fracture or a Greenstick fracture, and so on? Do we need antibiotics? Should a tetanus shot be given? In other words "injury" may be a sufficient description for an after-action report following a specific military mission. But it is much too imprecise for medical diagnosis and the reason we need an accurate diagnosis is to be able to provide the needed treatment.

What was so remarkable when PTSD was first introduced in 1980 was the recognition that the specific nature of the traumatic stress didn't seem to matter. Whether it was combat, rape, child abuse, surviving the Nazi Holocaust – the symptoms were the same: traumatic nightmares, avoidant behavior, hypervigilance, etc. PTSD was PTSD. Thirty-two years of research have fortified the robustness and importance of the original DSM-III diagnosis. The basic construct – that overwhelming stress can produce a consistent pattern of profound and enduring changes in brain function, cognition, emotions and behavior has stood the test

of time.

PTSD is PTSD: Abnormalities in brain function, neurobiological reactivity and psychological mechanisms observed in combat veterans apply equally to rape victims or motor vehicle accident survivors with PTSD. PTSD is PTSD: treatments originally developed for female rape victims rank among our most effective treatments for service members with PTSD.

Changing the name to PTSI in an attempt to reduce stigma among soldiers would reverse years of research and suggest that PTSI is something entirely different.

I don't think the change would reduce stigma and improve treatment-seeking behavior. PTSI would still be included in APA's Diagnostic and Statistical Manual, alongside all the other mental disorders. Service members with PTSI might still be relieved of certain assignments, such as going out on patrols that might further expose them to combat trauma. Service members with PTSI would still know their wounds are invisible. They'd still know that they weren't eligible for a Purple Heart even though their combat-related disability might be permanent and life-changing, whereas many Purple Heart recipients recover from their physical wounds completely and go on without any chronic impairment.

The argument for PTSI is that an injury is a physical wound whereas a disorder isn't. So the "I" would indicate an honorable injury whereas the "D" connotes a dishonorable disorder. But that is simply inaccurate. A disorder, whether PTSD or depression, reflects a disturbance in the biological, as well as the psychological or developmental processes underlying mental function. We know from abundant research that PTSD is clearly associated with biological alterations, especially in brain function. So is depression. According to this logic, we should call depression suffered in the war zone a "major depressive injury" to split it off from other depressive episodes.

There is also the matter of appropriate research and evaluation. There needs to be strong empirical evidence to support any changes from past diagnoses. And, to my knowledge, there is no scientific evidence that changing the name of any disorder will produce the desired changes in terms of stigma reduction and increased treatment-seeking behavior.

Rather than debating what to call this disability, we should be considering how to substantially and meaningfully reduce stigma so that service members with PTSD will come forward for treatment. We already know that affected military personnel recognize that they are not the man or woman they had been before the onset of their deployment-related PTSD. We don't have to convince them that there is something wrong.

What we have to do is: 1) help them understand what is wrong – is it PTSD or something else; 2) help them understand that this is a treatable condition; and 3) help create an environment through military and social policy that will reduce barriers to seeking treatment. I think the real challenge is changing the environment.

The US is making substantial progress via social media platforms, public health campaigns,

and through collaborative partnerships between the Department of Veterans Affairs and the Department of Defense as well as community organizations. There is still much more work that needs to be done in this country. We need to do a better job through public education and risk communication, to increase awareness about our very effective treatments for PTSD. We should look at what has been accomplished by the Canadian military as an example of how major changes in official policy regarding PTSD can make a substantive difference in reducing stigma and increasing treatment seeking without changing the medical diagnosis PTSD. In short, I believe we can accomplish even more.

In Canada, PTSD is classified as an Operational Stress Injury (OSI), along with other injuries to any part of the body sustained in combat. Those with an OSI are eligible for Canada's Sacrifice Medal, the equivalent to America's Purple Heart, whereas Americans with war-related PTSD are not eligible for this honorable recognition. The cornerstone of the OSI model involves many levels of peer support from colleagues who have developed PTSD or some other mental disorder in the line of dangerous combat duty. In Canada, there is widespread public education for service members, their families and the general public, which includes a very active speakers bureau where service members or veterans with PTSD spread the word about the program and their own personal experiences. This education program also includes a specific educational effort directed towards military leaders: generals and colonels at the company and battalion level down to Non-Commissioned Officers at the platoon level. This is crucial because the enlightened behavior of military leaders is a key positive influence on attitudes towards mental health and stigma reduction. There is no wrong door. Any Canadian service member with an OSI due to PTSD will find his or her way to the OSI social support network.

I believe there are many actions being taken, and many more that need to be taken to reduce the stigma of PTSD among service members so they will request effective treatments. I believe reducing the stigma is precisely where we should direct our collective focus because the likelihood of success is much greater than can be realistically expected from calling PTSD something else.

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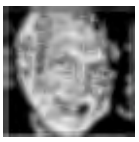

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