Posttraumatic Stress Disorder: A Hidden Epidemic

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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%.

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. We are quite used to hearing about mental health professionals rushing to the scene of a traumatic event—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. 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 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 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%.

REFERENCES