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Editorial

What Is PTSD?

> "What is war?" was the question with which I began this book. Now that I have finished . . . I hope I have called into doubt the belief that there is a simple answer to that question or that war has any one nature.
>
> —J. Keegan (1, p. 386)

What is posttraumatic stress disorder (PTSD)? What is the nature of the relationship between a traumatic stressor and the development of PTSD? A recent commentary in the *Journal* by Andreasen (2) has focused our attention on the historical development of PTSD. Tracing the evolution of the diagnosis, Andreasen outlined the forces that shaped the DSM-IV criteria. In addition, Cardena and co-workers have summarized the rationale for adding acute stress disorder to the diagnostic armamentarium (3). Yehuda and McFarlane's reassessment (4) of recent epidemiological and neurobiological investigations calls into question a number of the original assumptions underlying the diagnosis of PTSD, including the fundamental premise that links exposure to trauma with the development of the disorder. Two articles in this month's issue of the *Journal* present new findings that again challenge our current conceptualization of PTSD.

Litz et al. assess the nature of exposure to stress and the prevalence of PTSD among U.S. peacekeeping forces in Somalia. The authors evaluated combat stress exposure, positive and negative aspects of the peacekeeping experience, and PTSD symptom levels in Somali veterans approximately 5 months after completion of the mission. The 8% prevalence of PTSD in the cohort is similar to rates reported from the Gulf War (5) and demonstrates that like soldiers in times of war, peacekeepers are also at risk for the development of PTSD. Although combat experiences predicted later symptoms, other factors unique to the nature of the Somali peacekeeping mission were as important in predicting symptom severity. Frustrations with the peacekeeping mission, such as the need to exercise restraint and shifting rules of engagement, were found to be strong predictors of PTSD symptoms. In contrast, rewarding experiences during military deployment in Somalia, such as the development of relationships with other personnel, were found to be protective against the development of PTSD.

The article by Southwick et al. is an investigation of the consistency of adult memory for combat trauma in veterans of the Persian Gulf War. Southwick et al. assessed veterans' recollections of combat 1 month and 2 years after they returned from the Gulf. A key finding in this study was inconsistent recall for specific features of combat trauma in the majority of veterans. Seventy percent of subjects recalled traumatic events at 2 years that they had not reported at 1 month. Subjects with greater PTSD symptom levels were significantly more likely to "amplify" their memory of combat trauma at the 2-year assessment. As the authors point out, the association of changes in memory with greater PTSD symptom levels brings into question the retrospective methodology traditionally used to demonstrate a link between severity of combat exposure and the development of PTSD (5, 6).

Taken together, the results of these two studies have far-reaching implications for the assessment and treatment of PTSD. Litz et al. remind us that peacekeeping missions have unique demands, beyond exposure to combat stress, that may influence the development of PTSD. Recent developments in U.S. foreign policy, including the appointment of Madeleine Albright as Secretary of State, suggest that the United States will continue to aggressively deploy peacekeeping forces (7). Given that a significant percentage of troops involved in peacekeeping may return from their missions with PTSD, military and Veterans Affairs psychiatrists need to develop collaborative clinical and research programs that target early recognition and intervention. It is hoped that these efforts will curtail the development of chronic PTSD and the associated social and occupational impairment that have proven so devastating and difficult to treat in Vietnam veterans.

If the findings of Southwick et al. are replicated and it is verified that patients with greater PTSD symptoms amplify or distort memories of traumatic stressors, our most basic assumptions about the relationship between trauma and PTSD will be challenged. Commonly, a central focus in the clinical evaluation of patients is the linking of current symptoms to traumatic events that occurred months or years before treatment and an exploration of those events. In light of these new findings, our approach to assessing and treating the disorder requires reexamination. Because the recollection of past trauma may be distorted, findings by Southwick et al. encourage us to shift our attention to the assessment of current symptoms and their impact on current functioning and quality of life. The importance of this perspective is reinforced in the DSM-IV criteria for PTSD, which require that a patient present with "clinically significant distress or impairment in social, occupational, or other important areas of functioning" in order to meet full criteria for the disorder. Of course, an integrated treatment model for PTSD (8) would include not only an assessment of current symptoms and current functional impairment, but also, as Southwick et al. note, an empathic exploration of "the patient's current version of the past."

This shift toward functional assessment in PTSD becomes even more important as the detection and treatment of psychiatric disorders move to the primary care sector (9). A recent investigation reported that traumatic events and PTSD may be endemic in American civilian populations (10), suggesting that these patients may be prevalent in primary care. Within the time-constrained, pragmatically focused primary care setting, emphasizing the link between current symptoms and current functional impairment may increase the interest in, and recognition of, patients with PTSD.

Thus, the question, What is PTSD?, has no one answer. Surely our conceptualization of the disorder will continue to evolve, both with new scientific discoveries and with changes in the professional environment within which patients suffering from PTSD are treated.

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