



POSTTRAUMATIC STRESS DISORDER:

FRANK M. OCHBERG, M.D., ANSWERS COMMON QUESTIONS ABOUT PTSD

Frank M. Ochberg, M.D., was part of the team that wrote the diagnosis of posttraumatic stress disorder (PTSD). He recently spoke to the National Center for Victims of Crime about this condition which affects so many crime victims.

Q: How is posttraumatic stress disorder defined?

A: PTSD is a psychiatric condition triggered by exposure to horrific events that terrify you or make you feel helpless. It is manifested by the presence of three sets of symptoms or reactions occurring in the same month. The symptoms must occur for at least one month before a diagnosis of PTSD can be made. They don't always appear immediately and, in some cases, are delayed for decades. However, symptoms usually emerge close to the event.

Q: How did you come to be involved in working on trauma and related issues?

A: I was at the National Institute of Mental Health from the late 1960's to the late 70s in different posts, including the one that was responsible for the community mental health in the United States. But also, ultimately, the number three position at NIMH, the associate director. I was also involved with a lot of activities during that period of time that began for me with the assassinations of Martin Luther King and Bobby Kennedy. Eventually, I led an effort at Stanford to study and integrate various approaches to human violence. I ended up being the psychiatrist on the Attorney General's Task Force on Terrorism and Disorder and then the liaison from what was then the Department of Health, Education, and Welfare to the National Security Council. I did a lot of work on counter-terrorism and on hostage negotiation. The term "Stockholm Syndrome" came out of some of that work. I developed a strong interest in violence, cruelty, and preventing that instinct in us, and also in treating the impact. I was

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part of the team that wrote the diagnosis of posttraumatic stress disorder, and part of the founding board of the International Society for Traumatic Stress Studies.

Q: What are the three categories of symptoms?

A: The three sets of symptoms that lead to a diagnosis of PTSD are the replaying of the event in your mind, emotional numbing, and physiological changes in the autonomic nervous system that controls our fight, flight, and fear responses.

The first category of PTSD symptoms means that, without wanting to, your brain or your mind replays the traumatic event. Sometimes it replays the event in a way that is so vivid and real that you feel you are there. But it could also be a re-experiencing in a form that is very subtle. A strange sense in the pit of your stomach. A feeling of dread. The event echoes. It comes back to you.

Q: Are flashbacks included in this first category of response?

A: A flashback is classic, but it is relatively rare after you have gone through most of your recovery. A flashback means that you experience the event as it was in the first place. When you see a flashback, you know you have PTSD. That's a cardinal feature of the full-blown syndrome.

Q: Describe the second category of symptoms.

A: The second set involves an automatic anesthesia of most emotions. Your brain mechanisms, your emotional responses, are blunted. You feel numb. It may appear like depression, but it isn't necessarily the same mechanism as depression. It can even extend to physical sensations. One of my patients somehow managed to dissect her wrist down to the radial artery and she hardly knew what she was doing. She felt no pain. She was a biology teacher, and was fascinated with the dissection. I had to keep her from being sent to a locked ward because she wasn't crazy, she wasn't suicidal. She was having one of the extreme manifestations of PTSD: a numbing to the point that she got involved in a mechanical type of bizarre behavior. Usually the way this manifests itself is that you feel like a shell of the person you were, and you don't do things that you used to do for pleasure. That's the second part of it: numbing and avoidance.

Q: And the final type of reaction?

A: The third part involves a physiological shift in the autonomic nervous system that controls our fight, flight, and fear responses. There is a lowered threshold for anxious arousal. All that physiology is there for a reason. We have an ability to move our blood from our guts to our muscles, to have our pupils dilate, and to have our heart beat faster when we've got to respond to physical stress. But if all of that body wiring is off, then you can't sleep, you can't eat right, you can't concentrate, and you can't do your job.

So you take A, B, and C together and you've got PTSD. It's a real syndrome that hurts people. It is often particularly difficult to understand for next-of-kin, loved ones, friends, and employers.

Q: The three elements have to be there all at once and they have to be there for at least a month. Is that right?

A: For the diagnosis, yes. They don't have to be there at the exact same time, but they have to be evident within the same month. That's done in a somewhat artificial way when you have a database that says this person qualifies for having PTSD, and this other person, who had two out of the three categories one month and the third one the next month, does not qualify. Even though, as a doctor, I would treat them exactly the same way.

Q: It doesn't mean they don't have some genuine trauma reaction. It's just not PTSD.

A: Exactly. We call it PTSD for medical reasons and for scientific reasons so that we can do studies on it. Unfortunately, the same definition is in place in a court of law. So the person who does not meet the criteria of the diagnosis can still have a disability, can still have an impact from a tort or from a crime. They don't technically qualify as PTSD, but it is still often a situation where somebody is at fault and the victim needs medical attention.

Q: You mentioned earlier about the onset not always occurring right after the traumatic event, and sometimes even being years down the road. How common is that?

A: It's particularly common with children who are sexually abused in the family. It's common when social stigma or an overwhelming fear of recognizing mortality is stronger than the accepting of reality. There are other situations, too, in which the expression of PTSD gets delayed. For example, many people who go through war. You're in combat and your body is keeping score. It says take a breath. It's a trauma response. Then, when you get a chance to relax, maybe a year later, it hits you.

Q: Are you able to make any generalizations about the course of recovery for somebody with PTSD? Is there a typical course?

A: Yes. Of course, anyone in my position would give all the caveats about there being great differences according to the severity and type of the trauma and according to the condition of the victim, including in that condition the extensiveness or poverty of their human resources.

The course of recovery typically starts out with ignorance and a state of denial: "This is not me. I am not experiencing psychological difficulties. I can lick this on my own." There is failure to grasp reality. Then, there's often an alternation between anger and depression. Therapists often want to see anger because it's stronger and healthier than diminishing oneself and becoming suicidal. So these two elements sometimes alternate: one comes out first and the other comes out later. And then there's a period, a brief period, when you're working effectively, learning, recovering your sense of humor, recovering attachments to other people, dealing with life. Finally, in some cases, there is a reaching out to try to help other people. You don't see it in everybody, but you love to see it when it's there. And it's not helping others just a little bit, but an enthusiasm for helping others. So, that's the ultimate recovery. It's a lot more than recovery. It's not returning to some pre-existing state.

Q: You're a whole different person.

A: Sure, of course! And in a great sense it's both tragic and it's noble.

Q: And what about time frames? How long can recovery take? Is it different for every person?

A: The time spent has got to be proportional to the loss, the type of trauma, and the type of individual. Let me give you an example: Let's say your trauma is a car crash in which your wife and child are killed, and you're at the wheel and sustain a head injury. What if you have neurological damage plus crushing survivor's guilt from losing your family? That's very different from being robbed at gunpoint. And this will require a very different time course.

Q: So, is the answer, "It depends"?

A: Yes, but that doesn't stop an expert from giving a prognosis based on an analysis of a specific case. We can make a valid prognosis based upon events that we can add up for a given case.

Q: Should we be worried that unprecedented numbers of people who saw the attacks on the World Trade Center will develop PTSD?

A: I would say it's highly unlikely that the majority of people who saw these images will get PTSD. I think we're past the peak now. In the first days and weeks, these images were very much with us. We were troubled, almost haunted by them. Now, many people are recovering some of the normal rhythms of life.

We will never forget that day, where we were, who broke the news, who was with us at the time. This is called a flashbulb memory because it illuminates that part of personal history. It can illuminate very positive things—
Cwho we called, who was supportive. Most of us got in touch with the most important people in our lives rapidly, and we cared for one another.

So, for most people, when we remember these images, they will illuminate all of that as well.

Q: These attacks have caused many crime victims to re-experience earlier trauma. Do you have any suggestions for victim service providers who are reporting significant increases in their caseloads?

A: Some of the people we help have deep and enduring problems. It doesn't take much to bring them into consciousness. People who are anxious, isolated, or have low self-esteem can be expected to suffer.

As we help our clients we can point out that, while they are traumatized and troubled, they may also feel a sense of solidarity and connection around the world. We can say that we have a sense of optimism. It's good to pass that on to clients—
Cif you feel it genuinely.

This has brought many things into focus for many people. Many of these people worked hard to regain a sense of safety and control over their lives. When someone has a return of symptoms, we must remind them that PTSD is not trivial. It is profound, and, by definition, will re-occur. It doesn't mean they will go back to square one. They've been living and growing and moving away from the trauma. This is a time of remembrance, but not a return to it.