PTSD Myths[1]

For a variety of reasons, PTSD is a mental health condition that has spawned many myths. The following "urban myths" about trauma complicate the assessment, treatment, and insurance management of PTSD.

Some events are so traumatic that all exposed victims develop PTSD – This myth has evidently developed because of early diagnostic conceptualizations of PTSD ("The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone….")[2]. In fact, most research involving the conditional prevalence of PTSD following specific traumas suggests that no more than 10 to 20 percent of trauma victims suffer PTSD symptoms in excess of one year.[3]

Severity of trauma predicts severity of PTSD – By and large, the research literature has not been able to find a relationship between objective trauma severity and extent of psychological distress or severity of PTSD symptoms. Some evidence exists that severity of initial physical injury predicts PTSD in MVA victims, but this finding has not been consistently replicated. This is likely because the consequences of trauma are filtered through pre-existing characteristics of the victim (e.g., pre-existing resiliency) and the post-trauma environment (e.g., coping resources, residual health problems).

Motor vehicle accidents (MVAs) seldom result in PTSD – MVAs in which the victim suffers at least some minor injury are more likely to precipitate PTSD than combat or natural disaster exposure, and only marginally less likely than is sexual assault.[4]

Loss of consciousness from a head injury precludes the development of PTSD - In fact, rates of PTSD in MVA victims suffering mild traumatic brain injuries (MTBI) are similar to that suffered by MVA victims without TBI[5].

Early psychological debriefing of trauma symptoms will prevent PTSD – Psychological debriefing of trauma victims is ubiquitous. However, several studies lead to the conclusion that there is NO reliable decrease in PTSD symptoms from such debriefing[6].

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[2] American Psychiatric Association (1987*). Diagnostic and Statistical Manual of Mental Disorders: Third Edition - Revised.* American Psychiatric Association: Washington, D.C.

[3] For example; Norris, F.H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*, 409-418.

[4] Norris, F.H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*, 409-418.

[5] See, for example, Hickling, E.J., Gillen, R., Blanchard, E.B., Buckley, T., & Taylor, A. (1997). Traumatic brain injury and posttraumatic stress disorder: A preliminary investigation of neuropsychological test results in PTSD secondary to motor vehicle accidents, *Brain Injury, 12*, 265-274.

[6] See review by Fairbrother, N. & Koch, W.J. (January 21, 2001). *Preventing Psychological Distress Following Trauma: Current Knowledge and Future Directions*. Working Paper for the Insurance Corporation of British Columbia.