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John M Oldham, MD
President
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Dear Dr. Oldham:

We write to you in support of the request from the US Army Vice Chief of Staff, General Peter Chiarelli, that the American Psychiatric Association change the name Posttraumatic Stress Disorder (PTSD) to **Posttraumatic Stress Injury (PTSI)** in its next edition of the Diagnostic and Statistical Manual. This request pertains only to the name, and expresses no opinion on the existing DSM-IV or proposed DSM-V criteria.

General Chiarelli's request springs from the culture of the U.S. Armed Forces, which finds the label "Disorder" to be stigmatizing, compared to the term "Injury," which is not.

General Chiarelli speaks for the soldiers who suffer in silence. He has concluded that changing the name of PTSD to PTSI will reduce barriers to care, with palpable benefit to his service members, their families, and the nation.

General Chiarelli comes forward as suicide rates of young veterans are on the rise, as media attention to invisible wounds of war is increasing, and as next-of-kin struggle to overcome their loved ones' aversion to intervention.

In a PBS News Hour interview with producer Dan Sagalyn, the General elaborated:

*"It is an injury," Chiarelli said. Calling the condition a "disorder" perpetuates a bias against the mental health illness and "has the connotation of being something that is a pre-existing problem that an individual has" before they came into the Army and "makes the person seem weak," he added.*
*"It seems clear to me that we should get rid of the 'D' if that is in any way inhibiting people from getting the help they need," Chiarelli said. Calling it an injury instead of a disorder "would have a huge impact," encouraging soldiers suffering from the condition to seek help, according to the four-star general.*

Veterans are not alone in feeling this way.

Gloria Steinem sent us a personal communication in support of a change from disorder to injury, noting the beneficial effect this would have upon women as well as men. *"I think that's great, to change to injury....there are a whole raft of people who are adversaries to such (disorder) labeling."* Ms. Steinem addressed the APA in 1980, thanks to the efforts of the APA Committee on Women. Issues of sensitivity to language on behalf of our patients mattered then, as they do now. Survivors of rape and battering have reason to resent a stigmatizing label, when their posttraumatic reactions are consistent with an injury model.

**The Injury Model of PTSD**

To change PTSD to PTSI would mean we physicians believe that brain physiology has been injured by exposure to some external force, not that we are just anxious or depressed by tragic and traumatic reality. Here is the argument for the injury model.

From the earliest conversations about creating a new diagnosis, back in the late 1970s, we sought a concept that would capture the experience we had with survivors of catastrophic events - war, fires, floods, killing, rape. We didn't want the new syndrome to apply only to sensitive people or to people with pre-existing conditions. We knew that in mass disaster, some emerged with flashbacks and years of disabling symptoms, while others emerged sadder and affected, but not with the pattern we eventually called PTSD. We knew that some traumas were more traumatic than others - surviving forcible rape had, on average, more intense and prolonged symptoms than surviving a car crash. But we also knew that one could have a "clean bill of health" prior to the trauma, and then, afterward, there was a profound difference. That difference wasn't just being nervous or inhibited, it featured an altered form of memory : a traumatic memory. This is the core of PTSD - it is more than remembering something terrible; it is a change in the brain's pattern of memory. It resembles epilepsy. There are episodes, sometimes triggered and sometimes spontaneous, in which smells, or sensations, or garbled or clear pieces of the past come back. This happens during sleep, while awake, and in twilight states.

It is NOT autobiographical memory of a dreadful event. It is a "hot" memory, a traumatic memory, a different pattern of memory.

Think of it this way: in some survivors, but not all, exposure to extremely high amplitude signals of traumatic stress causes a change in brain physiology. This is analogous to altered hearing after a loud noise or altered vision after viewing an eclipse. The stimulus exceeds the capacity of an organ (in the case of PTSD, the capacity of the cortex of the brain) to receive that stimulus and retain its resiliency - its normal homeostatic capability.

The injury of PTSD is not necessarily permanent, just as other organ injuries can heal completely. But in chronic and complex cases, the injury remains for a long time and may be tolerated or may be seriously disabling.

Prior to a trauma that caused PTSD, there was no PTSD. After this shattering experience, the alteration in memory function, with unwanted, uncontrollable episodes of re-experiencing, persists.

It is not a weakness. It is really not, in its genesis and manifestation, a disease. To those who live with its impact, it is an injury--and a painful one at that.

Some see the key to the injury model as Paragraph B - the episodic, intense and exaggerated memory. No other diagnosis has this phenomenon. PTSD is unique. The person is not "disordered" but a brain function is injured. It no longer works the way it used to work.

Some see the injury as the persistence of valid adaptations to the real situation of surviving mortal danger. These adaptations, generically, fall into three groups corresponding to the DSM three headings for PTSD:
1. Remembering (actually, hyper-remembering) what it looked like, sounded like, smelled like, and felt like. This is the intrusive cluster.
2. Shutting down all mental and emotional functions that do not directly, in the moment, support survival of this danger. This is the numbing/avoidance cluster.
3. Mobilization of the mind and body for mortal danger. This is the hyperarousal cluster.

Like the mortar fragment, the primary psychological injury usually is not what kills or disables the survivor, but the complications do. It's the cascading complications and consequences that do most harm.

We are past the point in medical science when gross tissue damage is necessary for a wound. Alteration of myocardial conduction due to electrical shock, leaving no demonstrable bruise, is an injury with a grave consequence.

The MEG (magnetoencephalogram) research on veterans with PTSD, conducted within VA facilities, supports this injury model of PTSD ---http://www.scientificamerican.com/article.cfm?id=ptsd-diagnosis-brain-imaging-meg-neural-communications. The research suggests that the PTSD injury, resulting in *epileptiform memory*, has a signature in the electrical field of the brain.

**Time for a Change**

We are not only clinicians. We work closely with journalists, with authors, with leaders in government and with large lay audiences. They tell us that calling this posttraumatic condition an injury rather than a disorder will, over time, improve public respect for all those --women and men, civilians and military-- who suffer its symptoms.

We recall when civil rights leaders changed the label Negro to Black and then Black to African American.

It was time for a change. The change came from those who carried the label. Now we clinicians are being asked to change a designation by those who are so designated, and those who advocate for their dignity.

The American Psychiatric Association will be reasonable, responsive and just when it amends Posttraumatic Stress Disorder to Posttraumatic Stress Injury. The science supports an injury model. The DSM can live with a diagnostic acronym that doesn't end with "D." The time has come to listen to the labeled and to do what we can do to lessen the stigma and shame that inhibits our patients from receiving our help.

Respectfully yours,

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