Exposing Common Myths About PTSD  
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Despite an increased focus on posttraumatic stress disorder (PTSD) in the media and in society, popular myths about the disorder persist.

**Myth: All Stressful Events Are Traumatic**  
The word “trauma” is often used to describe a wide range of upsetting events. In order to be diagnosed with PTSD, an individual must have a history of exposure to a traumatic event that meets specific conditions. As such, it is important to understand what events are and are not considered to be traumatic. In the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5, APA, 2013), trauma is defined as exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event
- Witnessing the event in-person as it occurred to others
- Learning that the event occurred to a close family member or friend.
- Experiencing repeated and extreme exposure to aversive details of traumatic events (e.g., police and social workers are repeatedly exposed to details of abuse).

While many events (e.g., divorce, failing a test) can be very upsetting and stressful, they may not meet the DSM-5 trauma criteria; therefore, they cannot result in PTSD.

**Myth: Individuals Can Develop PTSD Immediately After Experiencing a Trauma**  
It is impossible to be diagnosed with PTSD immediately after trauma exposure. In fact, experiencing stress reactions following a traumatic event is common. In order to receive a diagnosis of PTSD, symptoms (e.g., intrusion, avoidance, negative alterations in cognitions and mood, and alteration in arousal and reactivity) must be present for more than one month.

**Myth: All Individuals Who Experience a Trauma Develop PTSD**  
Government data and surveys indicated that exposure to traumatic events is frequent. More than two-thirds of the general population may experience a significant traumatic event at some point during their lives, and up to one-fifth of people in the United States may experience such an event in any given year. Although exposure to traumatic events is fairly common, it is estimated that approximately 8% of trauma-exposed individuals develop PTSD. People are resilient.
**Myth: All Traumatized Individuals Need Treatment**

Traumatized individuals who do not develop PTSD may not require treatment. Research comparing traumatized youth with PTSD, traumatized youth without PTSD, and non-traumatized youth indicated the following:

- Traumatized youth with PTSD evidenced poorer functioning as compared to traumatized youth without PTSD and to non-clinical controls across measures of anxiety, verbal IQ, depression, misconduct, self-concept, anger, and academic achievement.
- Traumatized children without PTSD did not significantly differ from their non-traumatized counterparts across measures.

Basically, PTSD was consistently associated with poorer functioning across measures and trauma exposure without PTSD was not.

**Myth: PTSD is Not Real**

Differential validity research supports the diagnostic utility of PTSD. In addition, neuroimaging studies reveal structural and functional differences when comparing the brains of individuals with and without PTSD. Specifically, the hippocampus, the amygdala, and the ventromedial prefrontal cortex activate symptoms commonly associated with PTSD.

- **Hippocampus:** This region of the brain is responsible for memory functions, such as recording and retrieving memories and distinguishing between past and current memories. Individuals with PTSD exhibit reduced hippocampal volume. As such, they demonstrate difficulty distinguishing between past and present experiences and accurately interpreting environmental stimuli. For example, an extreme stress reaction may occur when the individual is confronted with environmental stimuli that vaguely resemble stimuli associated with a trauma (e.g., a door slamming may trigger the memory of a gun shot).
- **Amygdala:** This region of the brain processes emotions and is linked to fear responses. Individuals with PTSD evidence increased amygdala activity. Hyperactivity in the amygdala results in feelings of anxiety, fear, and extreme stress when individuals with PTSD are confronted with stimuli that are distantly associated or not associated at all with the traumatic event.
- **Ventromedial Prefrontal Cortex:** This region of the brain is responsible for regulating emotional responses triggered by the amygdala. Individuals with PTSD evidence decreased volume and functional ability in this region of the brain. As a result, individuals with PTSD may experience panic, anxiety, and stress even when faced with stimuli that are not associated with their traumatic experiences.

These structural differences help us to understand why individuals with PTSD may exhibit startle responses to neutral stimuli and demonstrate frequent flashback and intrusive recollections. Medication and cognitive behavioral therapy (CBT) have been shown to increase hippocampal volume in individuals with PTSD.

**Myth: There are No Successful Treatments for Individuals with PTSD**

There are highly effective medications and therapeutic treatments available for individuals with PTSD. The first step in the treatment of PTSD should be a comprehensive evaluation in order to
determine the severity and type of symptoms that the individual is experiencing. This assessment will also allow the clinician and client to use standardized measures in order to gauge symptom improvement and efficacy of treatment. Research has identified CBT strategies, such as prolonged exposure therapy, to be the most effective therapeutic intervention for PTSD.