

PTSD: National Center for PTSD

PTSD History and Overview

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A brief history of the PTSD diagnosis

The risk of exposure to trauma has been a part of the human condition since we evolved as a species. Attacks by saber tooth tigers or twenty-first century terrorists have probably produced similar psychological sequelae in the survivors of such violence. Shakespeare's Henry IV appears to meet many, if not all, of the diagnostic criteria for Posttraumatic Stress Disorder (PTSD), as have other heroes and heroines throughout the world's literature. The history of the development of the PTSD concept is described by Trimble (1).

In 1980, the American Psychiatric Association (APA) added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III) nosologic classification scheme (2). Although controversial when first introduced, the PTSD diagnosis has filled an important gap in psychiatric theory and practice. From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual (i.e., a traumatic event) rather than an inherent individual weakness (i.e., a traumatic neurosis). The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma."

Importance of traumatic events

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (such as earthquakes, hurricanes, and volcano eruptions), and human-made disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events to be clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial reverses, and the like. (By this logic, adverse psychological responses to such "ordinary stressors" would, in DSM-III terms, be characterized as Adjustment Disorders rather than PTSD.) This dichotomization between traumatic and other stressors was based on the assumption that, although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.

PTSD is unique among psychiatric diagnoses because of the great importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," which means that he or she has been exposed to an event that is considered traumatic. Clinical experience with the PTSD diagnosis has shown, however, that there are individual differences regarding the capacity to cope with catastrophic stress. Therefore, while most people exposed to traumatic events do not develop PTSD, others go on to develop the full-blown syndrome. Such observations have prompted the recognition that trauma, like pain, is not an external phenomenon that can be completely objectified. Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Because of individual differences in this appraisal process, different people appear to have different trauma thresholds, some more protected from and some more vulnerable to developing clinical symptoms after exposure to extremely stressful situations. Although there is currently a renewed interest in subjective aspects of traumatic exposure, it must be emphasized that events such as rape, torture, genocide, and severe war zone stress are experienced as traumatic events by nearly everyone.

Revisions to PTSD diagnostic criteria

The DSM-III diagnostic criteria for PTSD were revised in DSM-III-R (1987), DSM-IV (1994), and DSM-IV-TR (2000) (2-5). A very similar syndrome is classified in ICD-10 (The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines) (6). One important finding, which was not apparent when PTSD was first proposed as a diagnosis in 1980, is that it is relatively common. Recent data from the National Comorbidity Survey Replication indicates lifetime PTSD prevalence rates are 3.6% and 9.7% respectively among American men and women (7). Rates of PTSD are much higher in post-conflict settings such as Algeria (37%), Cambodia (28%), Ethiopia (16%), and Gaza (18%) (8).

DSM-IV Diagnostic criteria for PTSD included a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerned duration of symptoms; and, a sixth criterion stipulated that PTSD symptoms must cause significant distress or functional impairment.

The latest revision, the DSM-5 (2013), has made a number of notable evidence-based revisions to PTSD diagnostic criteria, with both important conceptual and clinical implications (9). First, because it has become apparent that PTSD is not just a fear-based anxiety disorder (as explicated in both DSM-III and DSM-IV), **PTSD in DSM-5** has expanded to include anhedonic/dysphoric presentations, which are most prominent. Such presentations are marked by negative cognitions and mood states as well as disruptive (e.g. angry, impulsive, reckless and self-destructive) behavioral symptoms. Furthermore, as a result of research-based changes to the diagnosis, PTSD is no longer categorized as an Anxiety Disorder. PTSD is now classified in a new category, Trauma- and Stressor-Related Disorders, in which the onset of every disorder has been preceded by exposure to a traumatic or otherwise adverse environmental event. Other changes in diagnostic criteria will be described below.

DSM-5 Criteria for PTSD diagnosis

As noted above, the **"A" stressor criterion** specifies that a person has been exposed to a catastrophic event involving actual or threatened death or injury, or a threat to the physical integrity of him/herself or others (such as sexual violence). Indirect exposure includes learning about the violent or accidental death or perpetration of sexual violence to a loved one. Exposure through electronic media (e.g. televised images the 9/11 attacks on the World Trade Center) is not considered a traumatic event. On the other hand, repeated, indirect exposure (usually as part of one's professional responsibilities) to the gruesome and horrific consequences of a traumatic event (e.g. police personnel, body handlers, etc.) is considered traumatic.

Before describing the B-E symptom clusters, it is important to understand that one new feature of DSM-5 is that all of these symptoms must have had their onset or been significantly exacerbated after exposure to the traumatic event.

The **"B" or intrusive recollection criterion** includes symptoms that are perhaps the most distinctive and readily identifiable symptoms of PTSD. For individuals with PTSD, the traumatic event remains, sometimes for decades or a lifetime, a dominating psychological experience that retains its power to evoke panic, terror, dread, grief, or despair. These emotions manifest during intrusive daytime images of the event, traumatic nightmares, and vivid reenactments known as PTSD flashbacks (which are dissociative episodes). Furthermore, trauma-related stimuli that trigger recollections of the original event have the power to evoke mental images, emotional responses, and physiological reactions associated with the trauma. Researchers can use this phenomenon to reproduce PTSD symptoms in the laboratory by exposing affected individuals to auditory or visual trauma-related stimuli (10).

The **"C" or avoidance criterion** consists of behavioral strategies PTSD patients use in an attempt to reduce the likelihood that they will expose themselves to trauma-related stimuli. PTSD patients also use these strategies in an attempt to minimize the intensity of their psychological response if they are exposed to such stimuli. Behavioral strategies include avoiding any thought or situation which is likely to elicit distressing traumatic memories. In its extreme manifestation, avoidance behavior may superficially resemble agoraphobia because the PTSD individual is afraid to leave the house for fear of confronting reminders of the traumatic event(s).

Symptoms included in the **"D" or negative cognitions and mood criterion** reflect persistent alterations in beliefs or mood that have developed after exposure to the traumatic event. People with PTSD often have erroneous cognitions about the causes or consequences of the traumatic event which leads them to blame themselves or others. A related erroneous appraisal is the common belief that one is inadequate, weak, or permanently changed for the worse since exposure to the traumatic event or that one's expectations about the future have been permanently altered because of the event (e.g., "nothing good can happen to me," "nobody can be trusted," "the world is entirely dangerous," "people will always try to control me"). In addition to negative appraisals about past, present and future, people with PTSD have a wide variety of negative emotional states such as anger, guilt, or shame. Dissociative psychogenic amnesia is included in this symptom cluster and involves cutting off the conscious experience of trauma-based memories and feelings. Other symptoms include diminished interest in significant activities and feeling detached or estranged from others. Finally, although individuals with PTSD suffer from persistent negative emotions, they are unable to experience positive feelings such as love, pleasure or enjoyment. Such constricted affect makes it extremely difficult to sustain a close marital or otherwise meaningful interpersonal relationship.

Symptoms included in the **"E" or alterations in arousal or reactivity criterion** most closely resemble those seen in panic and generalized anxiety disorders. While symptoms such as insomnia and cognitive impairment are generic anxiety symptoms, hypervigilance and startle are more characteristic of PTSD. The hypervigilance in PTSD may sometimes become so intense as to appear like frank paranoia. The startle response has a unique neurobiological substrate and may actually be the most pathognomonic PTSD symptom. DSM-IV's Criterion D2, irritability or outbursts of anger, has been separated into emotional (e.g., D4) and behavioral (e.g., E1) components in DSM-5. Irritable and angry outbursts may sometimes be expressed as aggressive behavior. Finally reckless and self-destructive behavior such as impulsive acts, unsafe sex, reckless driving and suicidal behavior are newly included in DSM-5, as Criterion E2.

The **"F" or duration criterion** specifies that symptoms must persist for at least one month before PTSD may be diagnosed.

The **"G" or functional significance criterion** specifies that the survivor must experience significant social, occupational, or other distress as a result of these symptoms.

The **"H" or exclusion criterion** specifies that the symptoms are not due to medication, substance use, or other illness.

Assessing PTSD

Since 1980, there has been a great deal of attention devoted to the development of instruments for assessing PTSD. Keane and associates (10), working with Vietnam war-zone Veterans, first developed both psychometric and psychophysiological assessment techniques that have proven to be both valid and reliable. Other investigators have modified such assessment instruments and used them with natural disaster survivors, rape/incest survivors, and other traumatized individuals. These assessment techniques have been used in the epidemiological studies mentioned above and in other research protocols.

Neurobiology

Neurobiological research indicates that PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems. Psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous system, increased sensitivity and augmentation of the acoustic-startle eye blink reflex, and sleep abnormalities. Neuropharmacological and neuroendocrine abnormalities have been detected in most brain mechanisms that have evolved for coping, adaptation, and preservation of the species. These include the noradrenergic, hypothalamic-pituitary-adrenocortical, serotonergic, glutamatergic, thyroid, endogenous opioid, and other systems. Structural brain imaging suggests reduced volume of the hippocampus and anterior cingulate. Functional brain imaging suggests excessive amygdala activity and reduced activation of the prefrontal cortex and hippocampus. This information is reviewed extensively elsewhere (11-12).

Longitudinal expression

Longitudinal research has shown that PTSD can become a chronic psychiatric disorder and can persist for decades and sometimes for a lifetime. Patients with chronic PTSD often exhibit a longitudinal course marked by remissions and relapses. There is also a delayed variant of PTSD in which individuals exposed to a traumatic event do not exhibit the full PTSD syndrome until months or years afterward. DSM-IV's "delayed onset" has been changed to "delayed expression" in DSM-5 to clarify that although full diagnostic criteria may not be met until at least 6 months after the trauma, the onset and expression of some symptoms may be immediate. Usually, the prompting precipitant is a situation that resembles the original trauma in a significant way (for example, a war Veteran whose child is deployed to a war zone or a rape survivor who is sexually harassed or assaulted years later).

Co-occurring conditions

If an individual meets diagnostic criteria for PTSD, it is likely that he or she will meet DSM-5 criteria for one or more additional diagnoses (13). Most often, these comorbid diagnoses include major affective disorders, dysthymia, alcohol or substance abuse disorders, anxiety disorders, or personality disorders. There is a legitimate question whether the high rate of diagnostic comorbidity seen with PTSD is an artifact of our current decision-making rules for the PTSD diagnosis since there are not exclusionary criteria in DSM-5. In any case, high rates of comorbidity complicate treatment decisions concerning patients with PTSD since the clinician must decide whether to treat the comorbid disorders concurrently or sequentially.

Classification and subtypes

PTSD is no longer considered an Anxiety Disorder but has been reclassified as a Trauma and Stressor-Related Disorder because it has a number of clinical presentations, as discussed previously. In addition, two new subtypes have been included in the DSM-5. The **Dissociative Subtype** includes individuals who meet full PTSD criteria but also exhibit either depersonalization or derealization (e.g. alterations in the experience of one's self and the world, respectively). The **Preschool Subtype** applies to children six years old and younger; it has fewer symptoms (especially in the "D" cluster because it is difficult for young children to report on their inner thoughts and feelings) and also has lower symptom thresholds to meet full PTSD criteria.

Questions to consider

Questions that remain about the syndrome itself include: what is the clinical course of untreated PTSD; are there other subtypes of PTSD; what is the distinction between traumatic simple phobia and PTSD; and what is the clinical phenomenology of prolonged and repeated trauma? With regard to the latter, Herman (14) has argued that the current PTSD formulation fails to characterize the major symptoms of PTSD commonly seen in victims of prolonged, repeated interpersonal violence such as domestic or sexual abuse and political torture. She has proposed an alternative diagnostic formulation, "complex PTSD," that emphasizes multiple symptoms, excessive somatization, dissociation, changes in affect, pathological changes in relationships, and pathological changes in identity. Although this formulation is attractive to clinicians dealing with individuals who have been repeatedly traumatized, scientific evidence in support of the complex PTSD formulation is sparse and inconsistent. For this reason, it was not included in the DSM-5 as subtype of PTSD. It is possible that the Dissociative Subtype, which has firm scientific support, will prove to be the diagnostic subtype that incorporates many or all of the symptoms first described by Herman.

PTSD has also been criticized from the perspective of cross-cultural psychology and medical anthropology, especially with respect to refugees, asylum seekers, and political torture victims from non-Western regions. Some clinicians and researchers working with such survivors argue that since PTSD has usually been diagnosed by clinicians from Western industrialized nations working with patients from a similar background, the diagnosis does not accurately reflect the clinical picture of traumatized individuals from non-Western traditional societies and cultures. It is clear however, that PTSD is a valid diagnosis cross-culturally (15). On the other hand, there is substantial cross-cultural variation and the expression of PTSD may be different in different countries and cultural settings, even when DSM-5 diagnostic criteria are met (16).

Treatment for PTSD

Most effective treatments for PTSD

The many therapeutic approaches offered to PTSD patients are presented in Foa, Keane, Friedman and Cohen's (2009) comprehensive book on treatment (17). The most successful interventions are cognitive-behavioral therapy (CBT) and medication. Excellent results have been obtained with CBT approaches such as prolonged exposure therapy (PE) and Cognitive Processing Therapy (CPT), especially with female victims of childhood or adult sexual trauma, military personnel and Veterans with war-related trauma, and survivors of serious motor vehicle accidents. Success has also been reported with Eye Movement Desensitization and Reprocessing (EMDR) and Stress Inoculation Therapy (SIT). Sertraline (Zoloft) and paroxetine (Paxil) are selective serotonin reuptake inhibitors (SSRIs) that are the first medications to have received FDA approval as indicated treatments for PTSD. Other antidepressants are also effective and promising results have recently been obtained with the alpha-1 adrenergic antagonist, prazosin (18).

A frequent therapeutic option for mildly to moderately affected PTSD patients is group therapy, although empirical support for this is sparse. In such a setting, the PTSD patient can discuss traumatic memories, PTSD symptoms, and functional deficits with others who have had similar experiences. This approach has been most successful with war Veterans, rape/incest victims, and natural disaster survivors. It is important that therapeutic goals be realistic because, in some cases, PTSD is a chronic, complex (e.g., with many comorbid diagnoses and symptoms), and severely debilitating psychiatric disorder that does not always respond to current available treatments. Resick, Nishith, and Griffin (2003) have shown however, that very good outcomes utilizing evidence-based Cognitive Processing Therapy (CPT) can be achieved, even with such complicated patients (19); and, more recently, group CPT has shown promising results (20-21). A remarkable recent finding is the effectiveness of group CPT, adapted for illiteracy and risk of ongoing violence, with sexual trauma survivors in the Democratic Republic of Congo (22). The hope remains, however, that our growing knowledge about PTSD will enable us to design other effective interventions for patients afflicted with this disorder.

Rapid interventions for trauma survivors

There is great interest in rapid interventions for acutely traumatized individuals, especially with respect to civilian disasters, military deployments, and emergency personnel (medical personnel, police, and firefighters). This has become a major policy and public health issue since the massive traumatization caused by the September 11 terrorist attacks on the World Trade Center, Hurricane Katrina, the Asian tsunami, the Haitian earthquake, the wars in Iraq and Afghanistan and other large-scale traumatic events. Currently, there is controversy about which interventions work best during the immediate aftermath of a trauma. Research on critical incident stress debriefing (CISD), an intervention used widely, has brought disappointing results with respect to its efficacy to attenuate posttraumatic distress or to forestall the later development of PTSD. The National Center for PTSD and the National Center for Child Traumatic Stress have developed an alternative early intervention, [Psychological First Aid](#) that is available online, but which has yet to be subjected to rigorous evaluation. On the other hand, brief cognitive behavioral therapy has proved very effective in randomized clinical trials (23).

Recommended Readings

Friedman, M. J. (2013). [Finalizing PTSD in DSM-5: Getting here from there and where to go next](#) (PDF). *Journal of Traumatic Stress*, 26, 548-556. doi: 10.1002/jts.21840 PILOTS ID: 87751

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Friedman, M. J. (2013). [PTSD in the DSM-5: Reply to Brewin \(2013\), Kilpatrick \(2013\), and Maercker and Perkonig \(2013\)](#) (PDF). *Journal of Traumatic Stress*, 26, 567-569. doi: 10.1002/jts.21847 PILOTS ID: 87755

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For help please see:

[Where to Get Help for PTSD](#) or
[Get Help with VA PTSD Care, Benefits, or Claims](#)

For Web site help: [Web Policies](#)

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