Posttraumatic Stress Disorder

Jump to:
- Causes
- DSM-5
- Dissociative PTSD
- Complex PTSD
- Chronic and Severe
- Children
- Delayed onset

What are the symptoms of PTSD?

Posttraumatic Stress Disorder (PTSD) is a very common mental health disorder, affecting 8.7% of people during their lifetime. The core symptoms are:
- re-experiencing the trauma psychologically (flashbacks and nightmares)
- avoiding reminders of the trauma
- emotional numbing
- hyperarousal (irritability, and being jumpy or constantly "on alert")

Who gets PTSD?

PTSD is also known as Post-traumatic Stress Syndrome (PTSS) and is not caused by normal, everyday stress.[1] PTSD can occur at any age, it can occur during childhood, adolescence, adulthood and old age.[1]:272-277

Recovery from PTSD

Recovery rates vary: the DSM-5 states around 50% of adults with PTSD may recover within 3 months but some people have PTSD for over a year. In some cases, PTSD has continued for over 50 years,[1]:277 for example in Vietnam war veterans and Holocaust survivors. Santiago et al. (2013) reviewed many studies of PTSD, finding that 50% recovered within 2 years.

As the graph shows, a third of people exposed to trauma develop PTSD (33%), and recovery is significantly quicker in people exposed to unintentional trauma, for example natural disasters, life-threatening illness or accidents.[8] Factors know to hinder recover, or worsen symptoms after trauma include:

- reminders of the original trauma
- normal 'life stressors', for example unemployment, illness or bereavement
- new traumatic experiences
- worsening physical declining health or cognitive function (in older people)
- social isolation can worsen symptoms [1]:277

See also: Treatments for PTSD

What causes PTSD?

Being female doubles the risk of a person developing PTSD; the reasons for this are not yet understood.[1]

The type of trauma experienced strongly affects the risk of developing PTSD; many studies show that rape causes the highest rates of PTSD,[1],[3] with over 50% of rape survivors affected.

Combat/military service is a less common cause of PTSD than many people expect, as the graph shows (based on research from Australian adults with PTSD in 2011).[45]

Rates of PTSD vary according to the type and duration of military service, along with many other factors affecting all trauma survivors, including the number of previous types of trauma experienced (both civilian and military), physical injuries sustained, whether there was social support after the trauma.[45]
There are three key groups of symptoms in PTSD, intrusion symptoms (such as flashbacks) and emotional numbing, are dissociative in nature. [23], [24] Emotional numbing is often referred to as “psychic numbing” or “emotional anesthesia”. Dissociative symptoms which occur within PTSD do not necessarily mean a Dissociative Disorder is present since the additional criteria for Dissociative Disorders are often not be met; however, PTSD is a common additional diagnosis for people with complex Dissociative Disorders including dissociative identity disorder.[20]:298

Dissociative symptoms, such as subjective sense of numbing or detachment, reduced awareness of an individuals surroundings, derealization, depersonalization, and dissociative amnesia, are cardinal features of posttraumatic stress disorder. [24]

**PTSD with dissociative features**

In the DSM-5 diagnostic criteria this as an optional specifier for PTSD, meaning some people will have these additional symptoms:

- With dissociative symptoms (with either depersonalization or derealization). [1]:272, [21]:1145

This is commonly referred to as the dissociative sub-type of PTSD, although it is actually a specifier in the DSM-5, and as described above all PTSD involves some dissociative features, so there is not a “non-dissociative PTSD”. The dissociative sub-type involves depersonalization or derealization rather than just additional dissociation, and is clinically different from severe PTSD. The criteria were summarized by Friedman (2013):28 as follows:

- All the PTSD criteria are met
- “High levels of depersonalization or derealization” are also present
- Dissociative symptoms are not linked to substance use or another medical condition
- it is found in both children and adults

A substantial study of data from the World Mental Health Surveys found that people with the Dissociative sub-type of PTSD had a higher number of major psychiatric disorders (comorbid DSM-IV “Axis I” disorders, for example depression, anxiety, excludes personality disorders).[14] They were also more likely to have a history of child abuse and neglect than those with "regular" PTSD.[6] Wolf et al. (2012) studied both men and women with PTSD, finding that repeated sexual assault or abuse was more common in people with the dissociative sub-type of PTSD, both child sexual abuse and adult sexual trauma. The women in this sample were more likely than the men to have avoidant or borderline personality disorder diagnoses in addition to PTSD.

Responses to trauma differ in people with the dissociative sub-type of PTSD, Most people with PTSD react to a personalized "trauma-script" with high levels of psychological distress and related physiological reactions, and greater reexperiencing symptoms (such as flashbacks), but those with the dissociative sub-type showed dissociative symptoms but lacked the other these symptoms. [6] For example, they had less awareness of surroundings/zoned out, felt depersonalized or experienced derealization. Brain activity also differed between the two groups.[6]

**PTSD in Young Children (PreSchool Sub-type)**

Infants and children aged six years old or younger can be diagnosed with PTSD, but young children's thinking and ability to express themselves in words is limited. This means both their symptoms and diagnostic criteria are slightly different from those in adults or older children.

Most of the research on Preschool PTSD involved three- to six-year-olds, with some studies also including younger children.[13] Babies and toddlers can have PTSD: the minimum age for diagnosis is one year old.[1]:272-274

The criteria for Preschool PTSD criteria are "developmentally sensitive". Some of the changes in wording include:

- constricted play is an example of “diminished interest in significant activities”
- social withdrawal or behavioral changes can indicate “feelings of detachment or estrangement.
- extreme temper tantrums are now included with “irritability or outbursts of anger”
- intrusive symptoms such as flashbacks and intrusive thoughts do not always manifest overt distress in preschool children

Scheeringa (2014) states that “while distressed reactions are common, parents also commonly reported no affect or what appeared
to be excitement" [13]

Fewer avoidance symptoms are included because avoidance is internalized, and harder to detect by observation, for example in pre-verbal children.

*Developmental Trauma Disorder* is a quite well-known term used to refer to *Complex PTSD* symptoms in children. [11] Like Complex PTSD it is caused by repeated and/or prolonged periods of trauma, for example child abuse by a familiar person. It was not included in the final DSM-5. [1]

Research has shown preschool children with PTSD have “impaired functioning” in many different areas of life, and the symptoms and impairment are stable in the long-term. [5] Very young children do not simple “bounce back” from PTSD. A study of 70 three- to six-year-olds directly by Hurricane Katrina found that children who stayed in New Orleans had significantly higher rates of PTSD than children who were evacuees (62.5%, compared to 43.5%). [12] None of the children who did not develop PTSD developed other mental disorders as a result of the trauma. The children were much more likely to have developed PTSD than their parents/caregivers; the “caregivers’ rate of PTSD was 35.6%, of which 47.6% was new post-Katrina”. This means that the hurricane’s impact nearly doubled the rate of PTSD in the adults, compared to before the trauma.

**Effects of PTSD on children**

Most children who develop PTSD also develop additional mental disorders (*comorbid disorders*) as a result of the trauma. In the case of Hurricane Katrina, the most common additional disorders were Oppositional Defiant Disorder and Separation Anxiety Disorder. A study of children 2–6 years old, and 7–10 years old, all traumatized by car crashes/motor vehicle accidents, found many differences between parents’ and their children’s reports of the trauma and its impact. This shows that relying solely on information from a parent of a traumatized child rather than the child leads to missing key information when assessing PTSD. [7] Given the subjective nature of the experience this is not surprising.

Effective treatments for infants and very young children with PTSD include Cognitive Behavioral Therapy (CBT), long-term, relationally-based treatment (e.g., in cases of interpersonal violence such as child abuse), Play Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and others. Trauma treatment methods need to be developmentally-appropriate to the child’s age.

See also: Dissociative form of PTSD
See also: Trauma and abuse

**Delayed PTSD**

PTSD with *delayed expression* occurs when the criteria for PTSD are not met for at least 6 months after the trauma; in some cases the onset of PTSD can be years after the trauma. This has been well documented and researched. [18]

A recent systematic review of 19 group studies indicated that delayed accounted for 38.2 and 15.3%, respectively of military and civilian cases of PTSD. [12] PTSD in the absence of any prior symptoms was extremely rare; this analysis found that delayed usually involved subsyndromal PTSD symptoms that later escalated to the full syndrome (possibly because of breakdown of very effective avoidance that previously worked to suppress reexperiencing symptoms and emotions for some period of time). [12] Delayed onset PTSD very uncommon after natural disasters, but it is not clear whether it is more likely to occur following military rather than non-military trauma. [25]

**Complex PTSD**

*Complex PTSD*, sometimes referred to as C-PTSD, or Disorders of Extreme Stress Not Otherwise Specified (DESnos), is caused by repeated traumatic events. It is not a separate clinic diagnosis in psychiatry but has previously been referred to as "PTSD and its Associated Features" in the DSM-IV (APA, 2000), and “Enduring Personality Change after Catastrophic Events” (EPCACE in the ICD-10, WHO (1992)). [26]

There is a significant relationships between complex PTSD symptoms and a history of sexual abuse, which is supported by a number of different studies. [27] Developmental Trauma Disorder (DTD) is the child equivalent to Complex PTSD. [11]

More information: Complex PTSD

**Chronic and Severe PTSD**

This section refers to research from PTSD resulting from a single traumatic experience, caused by physical or sexual assault/rape, rather than multiple experiences, although severe and persistent PTSD can be caused by multiple traumas as well.

*Chronic Posttraumatic Stress Disorder* refers to PTSD which lasts 3 months or longer, PTSD lasting under 3 months is known as acute...
PTSD; this classification was used in the DSM-IV diagnostic manual, but was removed by the DSM-5 changes.[18]:12, [1]:272 Chronic PTSD can vary in severity from mild to severe, but for many people is severe.

Negative views linked to persistent, chronic PTSD include:
- Nowhere is safe
- I cannot rely on other people
- I can’t trust my own judgments
- I am going mad
- It was my fault [2]

For example, persistently holding oneself responsible for causing the trauma or not avoiding it, or negative self-judgments about one's instinctive reactions during or after the trauma are linked to a longer duration of PTSD symptoms. These common negative beliefs are a symptoms of the trauma itself,[1]:272 and not an objective truth, sometimes these beliefs can be encouraged by people who wish to maintain their view of a "just world" rather than accept that a similar trauma could happen to them. People who are able to find some positive, for example, recognizing their own ability to have survived both the trauma and the horror of PTSD for so long, and identify positive qualities they did not have or were not aware of before, have a shorter duration to their PTSD. This has been referred to as Post-traumatic Growth (PTG). Besides the factors negative beliefs above, avoiding trauma reminders and seeking safety in order to control PTSD have been associated with more persistent PTSD.[2],[28],[29]

Severe PTSD
The diagnosis of PTSD does not include any description of what counts as mild, moderate or severe,[1]:272 but PTSD assessment tools are available to determine this. Factors during the time of trauma that lead to more severe PTSD:
- sense of hopelessness
- emotional detachment
- confusion [2]

A person's "perceived life threat" and "injury threat" during the trauma were found to be significantly correlated with PTSD severity at 4, 6 and 9 months after the trauma.[2] The person's perceived lack of control during the trauma was related to initial PTSD severity. Dunmore et al. (2001) found that the severity of a physical or sexual assault affected only the initial severity of PTSD, and the number of assailants affected only the longer-term severity (as measured at 9 months); other assault characteristics like time of day, duration of assault and relationship with the assailant were not found to be linked with the severity or persistence of PTSD (although most participants in the research were assaulted by a stranger at night, in a single traumatic event only). [2]

See also: Complex PTSD for PTSD from multiple interpersonal traumas, including child abuse
See also: Treatment for PTSD
See also: PCL-5 PTSD checklist test to help assess PTSD

PTSD caused by physical illness
PTSD can be caused by "exposure to actual or threatened death or serious injury" either by experiencing it yourself, or by witnessing it.[1] This includes medical illness for example being diagnosed with a serious or potentially terminal illness like cancer or HIV, or witnessing the effect someone else's medical treatment and/or death.[21]:143

PTSD, physical illness and cancer
Posttraumatic stress disorder has been studied in patients with heart problems, hemorrhage and stroke, childbirth, miscarriage, abortion and gynecological procedures, intensive care treatment, HIV infection, cancer and other conditions; with Favaro et al. (2011) finding that 12% of heart transplant recipients suffered PTSD as a result of the transplant. One study, which excluded cancer, found the highest rates were found in patients treated in Intensive Care Units (ICUs), and those with HIV infection. Wade et al. (2013) reviewed a number of studies of patients in critical care, and found risks of PTSD were higher with patients who were sedated for longer, were on mechanical ventilators for longer, were given benzodiazepines, experienced greater levels of fear and stress in the ICU and had frightening memories of admission. Tedstone and Tarrier (2003) found the severity of the physical illness did not predict the risk of PTSD. Poslusny et al. (2011) found that even the perceived threat of cancer caused PTSD; 15% of women with a non-life-threatening gynecologic disease met the diagnostic criteria for PTSD after gynecologic surgery which revealed they did not have cancer.[9]

Survivor Guilt and PTSD
Jim Polehinke was the only survivor of the 2066 Comair crash. He lives with the guilt - and blame.

**DSM-5 diagnostic criteria**

*Note: Slightly different criteria are used for PTSD in children aged 6 years old or younger.*

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   - Directly experiencing the **traumatic** event(s).
   - Witnessing, in person, the events(s) as it occurred to others.
   - Learning that the traumatic events(s) occurred to a close family member or close friend. In cases of actual or threatened by death of a family member or friend, the events(s) must have been violent or accidental.
   - Experiencing repeated or extreme exposure to adversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). This does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) occurred:
   - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). In children older than 6, there may be frightening dreams without recognizable content.
   - Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s).
   - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the trauma event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). In children, trauma-specific reenactment may occur in play.
   - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   - Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s)
   - Inability to remember an important aspect of the traumatic events(s) (typically due to dissociative amnesia and not to other
factors such as head injury, alcohol, or drugs).

- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "no one can be trusted," "the world is completely dangerous," "my whole nervousness system is permanently ruined.").
- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
- Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following.

- Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbances

F. Criteria B, C, D and E last more than 1 month. G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. H. The disturbance is not attributable to the effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:
- With dissociative features
  - Depersonalization
  - Derealization

Specify if:
- With delayed expression

This must be specified if the full criteria are not met until at least 6 months after the traumatic event; the criteria may be partially met during this time. [1]:272-274

Changes between the DSM-IV & DSM-5

PTSD is not an Anxiety Disorder

Posttraumatic stress disorder, along with Acute Stress Disorder, have moved from the Anxiety Disorders section to the newly created Trauma- and Stressor-Related Disorders, which recognizes that the symptoms are broader than Anxiety alone.[1]

New PTSD Symptoms in the DSM-5

- erroneous self-blame or blaming others for the trauma
- negative mood states
- reckless and maladaptive behavior, e.g. example reckless driving
- the irritability symptoms has criterion been changed to aggressive behavior, which includes verbal aggression but does not refer to violence[18] [1]:272-274
- illusions and hallucinations, which were listed as trauma symptoms (along with dissociative flashback episodes)
- the DSM-IV delayed onset specifier has been reworded to delayed expression; this is used when symptoms were delayed for at least 6 months after the trauma. Some PTSD symptoms may begin immediately after the trauma. [1]:273-274

PTSD Symptoms removed

The only significant symptom removed is the optional symptom A sense of a foreshortened future, which means the person doesn’t expect to have a career, marriage, children, or a normal life span

New PTSD Sub-types

Two new sub-types have been added, the PTSD dissociative sub-type and PTSD preschool sub-type. The Dissociative sub-type of PTSD has "prominent dissociative symptoms" which can be either Depersonalization (feeling detached from one’s own mind and/or body), or Derealization (experiencing the world as unreal, dreamlike or having distorted perceptions). The Preschool sub-type of PTSD is for children younger than six years of age. [18]

Confusingly, the Dissociative form of PTSD is described as a "sub-type" but the diagnostic criteria lists "with dissociative symptoms"
is a **specifier** instead of a sub-type. [1]

**PTSD Illusions and Hallucinations**

The DSM-5 clearly states that “illusions and hallucinations” can be PTSD symptoms. A particular type of auditory pseudo-hallucination, hearing your own thoughts spoken out loud in one or more voices, which may be described as hearing voices, is a recognized feature of PTSD. *Paranoia* (paranoid ideation) is also a possible result of PTSD.[1]:276

This improves upon the “Notes on flashbacks and psychotic hallucinations” section which was in the additional information in the PTSD section of the DSM-IV-TR and stated the importance of distinguishing between flashbacks and psychotic hallucinations:

“Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in Schizophrenia, other Psychotic Disorders, Mood Disorder with Psychotic features, a delirium, Substance-Induced Disorders, and Psychotic Disorders Due to a General Medical Condition.” [22]:467

**Traumatic Bereavement and PTSD**

This happens when PTSD is caused by the death of a loved one in sudden or distressing circumstances, e.g. suicide, murder or witnessing the death in traumatic circumstances.

See Traumatic Bereavement

**Denial of PTSD**

People with posttraumatic stress disorder may experience denial about the condition, in addition to amnesia, avoidance, minimization of the effects of the trauma and/or cognitive impairment. Each of these can affect whether the person will be diagnosed with PTSD, and the severity determined. “Collateral reports” can be used to add information from spouses/partners, friends or family and from prior medical reports. The spouse/partner (S/P) Mississippi scale was developed to aid collateral assessment [30]:264-265

Some clinicians may at times minimize the effects of the trauma, or fail to recognize trauma which is not in the given examples of types of trauma for diagnosis (e.g., threatened death, serious injury, war, rape or sexual violence or witnessing a major trauma). Cash (2006) states that even a clinician who is aware of the trauma and PTSD symptoms may deny the PTSD diagnosis. Writing in 1997, Cash stated that “most mental health professionals do not receive much (if any) training or experience with [trauma] disorders during their graduate training.”[1]:290 [31]:4-5 This could be because PTSD was not given a separate category in the DSM until 1980; although "traumatic stress" was included from the first edition.

**Comorbid disorders**

It is typical for people with PTSD to have other disorders which are caused by the effects of the trauma.[45] Approximately 80% of people also have other mental disorders, and a persistent “negative mood” or inability to feel positive emotions is part of the diagnostic criteria. Unsurprisingly, Depression (Major Depressive Disorder and other forms), Anxiety Disorders and Substance Misuse (alcohol, drugs or prescription medication) are the most common disorders.[45] Many people with Borderline Personality Disorder have PTSD, and a history of childhood physical or sexual abuse is fairly common in people with PTSD.[20]:685 Most people with Dissociative Identity Disorder also have PTSD, although rates of Dissociative Identity Disorder and Dissociative Disorders are significantly lower than PTSD. Dissociative Identity Disorder is caused by childhood trauma only.[20]:278

**PTSD and Suicide Risk**

The suicide risk is increased in people who have experienced trauma, with those who have PTSD being at greater risk compared to those who did not develop PTSD after the trauma. PTSD is associated with both suicide attempts and suicidal ideation. [20]:278, 803

**Traumatic Brain Injury, ASD & PTSD**

*Acute stress disorder* may occur immediately before PTSD, and the symptoms are similar (Acute Stress Disorder is diagnosed only within a month of a traumatic event). Traumatic Brain Injury (TBI) can be comorbid with PTSD, and many symptoms overlap; the combination of Traumatic Brain Injury and PTSD is particularly common in military veterans and occurs only in cases of physical injury to the head.

Symptoms of TBI which do not occur in PTSD are the reexperiencing and avoidance symptoms (DSM criteria B and C), and symptoms of Traumatic Brain Injury which are not present in PTSD are "persistent disorientation", and confusion. [20]:280 *Traumatic brain injury* (TBI) is “a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force”. Mild TBI is known as mTBI. (Department of Veterans Affairs) [37] TBI is often comorbid with PTSD.[38]

**History of PTSD**
Posttraumatic Stress Disorder first became an official diagnosis in 1980, when it was included in the Anxiety Disorders section of the DSM-III psychiatric manual.[32] Before 1980 the symptoms of Posttraumatic Stress was represented in both the DSM-I (in 1952) [33],[34] and the DSM-II (1968), and in medical literature under a variety of different names.[35], [39]

**Historical names for Posttraumatic Stress Disorder**
- 1870: Soldier's Heart is described by Charles Samuel Myers, a British military psychiatrist, and later by Da Costa (1871), based on his experiences in the American Civil War.[42]:20, [43]
- 1860: The first understanding that a traumatic event could cause psychological as well as physical injury. People traumatized by accidents on railways were referred to as having Railroad Spinal Syndrome by the English surgeon Frederick Erichsen. [39]:2, [40]:624 Erichsen believed concussion of the spine to be the cause of the accident survivors' "fear, fright and alarm".[40]:624
- 1882: Jean-Martin Charcot's work with traumatized patients in led to him use the terms "Névrose Traumatique" and "Hystérie Traumatique" (Traumatic Neurosis and Traumatic Hysteria) to classify patients with post-traumatic symptoms, regarding them to have an "inherited predisposition". He claimed that physical injury could produce psychological symptoms. Charcot later made significant contributions to the current understanding of Dissociative Identity Disorder (Multiple Personality Disorder). [2]:624
- 1883: John Putnam claimed that many cases of "Railroad Spinal Syndrome" were actually Hysterical Neuroses.[2]:624
- 1885-1889: Traumatic Neurosis was used by Hermann Oppenheim, a German neurologist, to describe PTSD symptoms. Oppenheim claimed there was a physical "disturbance" in the cerebrum (within the brain). This began the use of word trauma in psychiatry, rather than solely in surgery.[2]:624, [42]:20
- 1885: Nervous shock and Functional Disorder were terms introduced by surgeon Henry Page. Page discounted any spinal cause for PTSD symptoms, stating that nervous shock was psychological but caused the body's nervous system to malfunction.
- 1915: Charles Myers uses the term "shell-shock" in medical literature, but soldiers never directly in combat.
- World War I: "disorderly action of the heart" and "neurocirculatory asthenia" are used to describe PTSD symptoms.[42]:20
- 1926: Denial of PTSD as an illness. German psychiatrist Bonhoeffer and his colleagues founded a "school of thought" regarding traumatic symptoms as "social illnesses" that could "only be cured by social remedies". Patients were regarded as having inherent weaknesses, and were not actually suffering an illness but were motivated by compensation from insurance. As a result, people with "traumatic neurosis" were no longer given compensation.[42]:20
- 1952: DSM-I psychiatric manual published in the USA. Gross Stress Reaction describes the main PTSD criteria, and is included in the "Transient Situational Personality Disorders" section.[41]:16
- 1968: DSM-II published, with PTSD recognized as a Transient Situational Disturbance and no longer groups within personality-related disorders. The new name is Adjustment reaction of adult life, given code 307.30 and grouped with the several other conditions:
  - Example: Resentment with depressive tone associated with an un-wanted pregnancy and manifested by hostile complaints and suicidal gestures.
  - Example: Fear associated with military combat and manifested by trembling, running and hiding.
  - Example: A Ganser syndrome associated with death sentence and manifested by incorrect but approximate answers to questions.[35]:49
The disorder is expected to improve as the stress is reduced, another disorder is suggested for those not cured by the end of the stress, making this closer to Acute Stress Disorder than PTSD.
- Vietnam war and the women's movement lead to greater public interest and more research. Rape Trauma Syndrome is defined, including common PTSD symptoms and interpersonal effects (e.g., loss of trust).
- 1980: DSM-III published, revised as the DSM-III-R in 1987. The manual contains agreed diagnostic criteria for the first time. Posttraumatic Stress Disorder introduced as a separate diagnosis in the Anxiety Disorders section. PTSD can be either Acute (short-term), Chronic or Delayed. "Dissociative-like states" are referred to as a rare consequence of PTSD, a separate Dissociative Disorders section is also created. [DSM-III:236-238]
Possible PTSD causes are: rape, assault, military combat, natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or "deliberate man-made disasters" (bombing, torture, death camps). PTSD is a frequently caused by torture, but only occasional car accidents). More severe and longer lasting PTSD is normally caused by trauma of "human design".
- 2013: DSM-5 published. Posttraumatic Stress Disorder and Acute Stress Disorder are moved from the Anxiety Disorder section to a newly-created Trauma and Stressor-related Disorders section. A dissociative form of PTSD is introduced. Complex PTSD is debated for inclusion but left out.[1]

Another diagnostic manual, the International Classification of Diseases (ICD) which is produced by the World Health Organization, and originally focused on physical illness only, first including a section of mental disorders in the ICD-6 version, published in 1948.[36]
References


5. Friedman, M. J. (2013). Trauma and Stress-Related Disorders in DSM-5 (presentation used for expert training, ISTSS Conferences)


25. American Psychiatric Association DSM 5 PTSD


Cite this page


This information can be copied or modified for any purpose, including commercially, provided a link back is included. License: CC BY-SA 4.0