# Introduction

# Repairing the Shattered Self: Recovering From Trauma

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Posttraumatic stress disorder (PTSD) has a long history, although the name appeared first in 1980 when the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) was published.[1] Earlier literature refers to conditions that are essentially the same as PTSD by different names.

For example, such terms as *effort syndrome*, *DaCosta's syndrome*, and *railway spine* were all very fashionable in the 19th century. Earlier in this century, terms like *shell shock* and *soldier's heart* referred to the emergence of PTSD in World War I. Later, other terms—*combat fatigue*, *combat neurosis*, *post-rape syndrome*, *post-Vietnam syndrome*, *accident neurosis*, and *compensation neurosis*—all described the syndrome currently called PTSD.

The current criteria for the syndrome, as described by DSM-IV,[2] are complex. First (the A criterion), the person has been exposed to a traumatic event involving both of the following:

1. The person has experienced, witnessed, or been confronted with an event that involves actual or threatened death or injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.

The A criterion thus includes an objective component, the event, and a subjective component, the individual's appraisal and emotional reaction.

Symptoms are divided into three categories, reexperiencing (B criteria), persistent avoidance (C criteria), and increased arousal (D criteria). The reexperiencing symptoms—the B criteria—include:

- Recurrent, intrusive, distressing recollections of the trauma
- Recurrent, distressing dreams of the event—very true-to-life nightmares
- Sense of reliving the experience (flashbacks)
- Intense psychological distress at exposure to trauma reminders (internal or external)
- Psychological reactivity on exposure to trauma reminders

At least one of these five symptoms must be present to make the diagnosis of PTSD.

The second set of symptoms—the C symptoms—consists of persistent avoidance and numbing. The diagnosis of PTSD requires at least one of the first two and one of the remaining five. They are:

- Efforts to avoid trauma-related thoughts or feelings
- Efforts to avoid trauma-related activities, situations, or people
- Psychogenic amnesia
- Diminished interest in activities
- Detachment from others
- Restricted range of affect (numbing)
- Foreshortened future

Obviously, there is a considerable overlap between PTSD and some of the changes seen in patients with major depression.

Lastly, at least two of the D symptoms of increased arousal are necessary for the diagnosis of PTSD.

- Sleep disturbance
- Irritability or difficulty regulating anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

Some of these symptoms overlap with those of generalized anxiety disorder and depression. All symptoms must last more than a month and cause clinically significant distress or impairment in functioning.

DSM-IV categorizes PTSD as an anxiety disorder. Common to all anxiety disorders is a conflict between the tendency to attend to threat information and the tendency to avoid elaboration of such information (i.e., behavioral and cognitive avoidance).

What distinguishes PTSD is a biphasic reliving and denial, with alternating intrusive and numbing responses.[2] The numbing responses occur when efforts to reduce distress by active avoidance fail.

The high prevalence of PTSD, with its high comorbidity and increased health service utilization, makes it a significant public health concern. But even chronic cases may respond to well-selected treatments. The following articles discuss the prevalence, risk factors, course, and comorbidity of PTSD; its psychobiology; the presentation and treatment of PTSD in women assaulted physically or sexually; behavioral and medical treatments; and directions for future research in diagnosis and treatment.



**REFERENCES**

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC: American Psychiatric Association; 1980
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994

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*Previously presented at the symposium "Repairing the Shattered Self: Recovering From Trauma," held May 5, 1996, New York, N.Y., sponsored by the American Psychiatric Association and supported by an unrestricted educational grant from the Roerig Division of the U.S. Pharmaceuticals Group, Pfizer Inc.*

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