Journal of Trauma & Treatment
ISSN: 2167-1222

Fink, J Trauma Treat 2013, S4
DOI: 10.4172/2167-1222.S4-009

Short Communicaion Open Access

Posttraumatic Stress Disorder: Introduction to Special Issue

George Fink*

Florey Institute of Neuroscience and Mental Health, University of Melbourne, Australia

Posttraumatic Stress Disorder (PTSD) is a common condition in which a traumatic event is persistently re-experienced in the form of intrusive recollections, dreams or dissociative flashback episodes. Cues to the event lead to distress and are avoided, and there are symptoms of increased arousal. To meet the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5), the full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational or other areas of functioning [1].

PTSD has only been accepted officially as a mental disorder since 1980, when it was included, amid considerable controversy, in the DSM-III. References to the after effects of psychological trauma date back as far as the third century BC and were regarded as the basis for hysteria at the turn of the 19th Century by neurologists and psychiatrists such as Jean-Martin Charcot, Pierre Janet and Sigmund Freud [2,3]. Interest in PTSD increased dramatically during World War I. Charles Samuel Myers [4] was the first to coin the term and report case histories of 'shell shock', which described a condition that afflicted many troops who screamed and wept uncontrollably, froze and could not move, became mute and unresponsive, and lost their memory, sensations and capacity to feel. The condition occurred again in vast numbers of people as a consequence of World War II. However, it was the psychological trauma experienced by US Vietnam veterans and their demand for compensation that led to the inclusion of PTSD in the DSM-III as a condition that occurred both in civilian (e.g. rape trauma, battered woman and abused child syndromes) and in military trauma response syndromes. Genetic factors likely play a role in determining susceptibility or resilience to the impact of trauma, but studies on identical twins suggest that the majority of psychiatric symptoms reported by combat veterans with PTSD are acquired [5,6]. PTSD is characterized by hyperarousal, including exaggerated startle response, insomnia, irritability, and concentration difficulties, and increased sympathetic and adrenomedullary activity (e.g. increased skin conductance, heart rate, blood pressure and catecholamine secretion). Hyperactivity of the peripheral sympathetic and central adrenergic system in PTSD is reflected by the clinical improvement that occurs in patients with PTSD in response to agents that reduce the centrally hyperactive noradrenergic state. In contrast, the role of the hypothalamic-pituitary-adrenocortical (HPA) axis in PTSD remains controversial in that plasma cortisol concentrations have been reported to be decreased, increased or normal in PTSD patients. This contrasts markedly with the generally robust increase in HPA activity that occurs in acute stress and in major depressive disorder [1].

Posttraumatic Stress Disorder is the main subject of this special issue of the Journal of Trauma & Treatment. The subjects range from *Trauma History and Juvenile Sexual Offending* to *Psychological Trauma: Experience from Iraq* and *Eye Movement Desensitisation and Reprocessing* (EMDR) *Treatment of Posttraumatic Stress*. There is substantial empirical support for the efficacy of EMDR, a behavioral therapy that falls under the umbrella of cognitive-behavioral therapy (CBT) aimed at helping patients by exposure to confront safe reminders of their trauma and disconfirm their dysfunctional, unrealistic perceptions emerging from the traumatic experience [7]. Altogether, this special issue covers key aspects of PTSD and highlights areas where further robust research is required.

References

1. Fink G (2011) Stress controversies: post-traumatic stress disorder, hippocampal volume, gastroduodenal ulceration*. J Neuroendocrinol 23: 107-117.
2. Fink G (2009) Stress: definition and history. In: Squire LR, ed. Encyclopedia of Neuroscience, Vol. 9. Oxford: Academic Press / Elsevier: 549-555.
3. Lasiuk GC, Hegadoren KM (2006) Posttraumatic stress disorder part I: historical development of the concept. Perspect Psychiatr Care 42: 13-20.
4. Myers CS (1915) A contribution to the study of shell shock. Lancet 1: 316-320.
5. Pitman RK, Rasmusson AM, Koenen KC, Shin LM, Orr SP, et al. (2012) Biological studies of post-traumatic stress disorder. Nat Rev Neurosci 13: 769-787.
6. Gilbertson MW, McFarlane AC, Weathers FW, Keane TM, Yehuda R, et al. (2010) Is trauma a causal agent of psychopathologic symptoms in posttraumatic stress disorder? Findings from identical twins discordant for combat exposure. J Clin Psychiatry 71: 1324-1330.
7. Foa EB, Gillihan SJ, Bryant RA (2013) Challenges and successes in dissemination of evidence-based treatments for posttraumatic stress: lessons learned from prolonged exposure therapy for PTSD. Psychological Science in the Public Interest 14: 65-111.

***Corresponding author:** George Fink, Florey Institute of Neuroscience and Mental Health, University of Melbourne, 30 Royal Parade, Parkville, Victoria 3010, Australia, E-mail: george.fink@florey.edu.au

Received January 03, 2014; **Accepted** January 17, 2014; **Published** January 20, 2014

Citation: Fink G (2014) Posttraumatic Stress Disorder: Introduction to Special Issue. J Trauma Treat S4: 009. doi:10.4172/2167-1222.S4-009