POSTTRAUMATIC STRESS DISORDER (PTSD)

Authored by

mohammad looti

October 11, 2025

RECOMMENDED CITATION

mohammad looti (2025). *POSTTRAUMATIC STRESS DISORDER (PTSD)*. PSYCHOLOGICAL SCALES. Retrieved from https://scales.arabpsychology.com/?p=43209

ARABPSYCHOLOGY.COM

POSTTRAUMATIC STRESS DISORDER (PTSD)

Primary Disciplinary Field(s): Psychology, Psychiatry, Clinical Neuroscience

1. Core Definition

Posttraumatic Stress Disorder (**PTSD**) is a debilitating psychiatric condition that may develop after an individual has experienced, witnessed, or learned about one or more traumatic events. In the context of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), this trauma must involve actual or threatened death, serious injury, or sexual violence. The source material specifically referenced the criteria found in the prior revision, the DSM-IV-TR, which characterized the disorder as stemming whenever someone survives, endures, or witnesses an occurrence wherein they believe that there is a risk to life or physical integrity and safety, accompanied by experiences of **fear**, **horror**, or **helplessness**. Fundamentally, PTSD is defined by a failure to recover after experiencing or witnessing a terrifying ordeal, resulting in a persistent, severe cluster of symptoms that significantly impair the individual's social, occupational, and other critical areas of functioning. The core of the disorder involves the intrusion of the traumatic memory, efforts to avoid reminders of the trauma, negative alterations in cognition and mood, and marked changes in arousal and reactivity, all persisting for more than one month following the event.

The diagnosis requires that these symptomatic clusters cause clinically significant distress or impairment in functioning. Unlike generalized anxiety disorders, PTSD is unique because it is etiologically linked directly to a specific, identifiable traumatic stressor. The severity and manifestation of PTSD can vary widely, sometimes presenting as delayed onset, where the full diagnostic criteria are not met until at least six months after the event. Furthermore, specific subsets of the disorder, such as the dissociative subtype, are recognized in the most current diagnostic classifications, highlighting the complex ways in which the mind attempts to cope with overwhelming psychological injury. Understanding PTSD requires acknowledging that the traumatic event shatters the individual's basic assumptions about safety and predictability, leading to profound disturbances in emotional regulation and self-perception that extend far beyond simple fear responses.

ARABPSYCHOLOGY.COM

2. Etymology and Historical Development

The symptoms associated with PTSD have been documented across millennia, often referred to by different names reflecting the cultural and historical understanding of trauma. During the American Civil War and World War I, these presentations were frequently termed "**soldier's heart**" or "**shell shock**," reflecting the belief that the symptoms were caused by physical damage to the brain from concussive blasts. Following World War II, the concept evolved into "combat fatigue" or "gross

stress reaction," suggesting a temporary, immediate response to acute stress rather than a chronic condition. These early conceptualizations often minimized the psychological components, focusing instead on physical or transient exhaustion.

The modern recognition of PTSD as a distinct diagnostic entity was critically influenced by the experiences of Vietnam War veterans and survivors of severe civilian trauma, such as the Holocaust. It was recognized that the constellation of intrusive memories, avoidance behaviors, and hyperarousal could not be adequately explained by existing diagnoses like general anxiety or depression. The formal inclusion of Posttraumatic Stress Disorder in the DSM-III in 1980 marked a pivotal shift, establishing the disorder as one primarily rooted in psychological trauma, regardless of whether the stressor was war-related or civilian. This classification legitimized the struggles of trauma survivors and catalyzed extensive research into the neurobiological and psychological mechanisms underlying chronic trauma reactions. The criteria established in the DSM-III and carried forward into the DSM-IV-TR emphasized the necessity of a severe stressor and the subsequent triad of symptom clusters: re-experiencing, avoidance/numbing, and hyperarousal, criteria which largely informed the summary provided in the source material.

3. Key Symptom Cluster I: Intrusion (Re-experiencing)

The first hallmark of PTSD, and a crucial indicator cited in the source content, is the involuntary and distressing re-experiencing of the traumatic event. This cluster of symptoms involves the traumatic memory repeatedly breaking into conscious awareness in the present moment, often with the feeling that the event is happening again. The symptoms are marked by painful **flashbacks**, involuntary and recurrent distressing **recollections**, or repetitive dreams or nightmares related to the trauma. These intrusive symptoms are typically severe enough to cause intense psychological distress and significant physiological reactivity when they occur, differentiating them from simple memories or bad dreams.

Flashbacks are particularly disruptive, involving dissociative reactions in which the individual feels or acts as if the traumatic event were recurring. During a flashback, the survivor may temporarily lose contact with reality and re-enter the psychological state of the trauma. The intensity of re-experiencing symptoms often fluctuates, triggered by internal cues (thoughts, emotions) or external cues (sights, sounds, smells) that symbolically resemble aspects of the original trauma. This constant threat of intrusion explains why affected individuals exert so much psychological effort into avoidance behaviors, desperately attempting to suppress the highly charged memory fragments.

4. Key Symptom Cluster II: Avoidance

The second critical domain involves persistent effortful avoidance of stimuli associated with the

ARABPSYCHOLOGY.COM

trauma. This avoidance serves as a coping mechanism against the overwhelming emotional pain and intrusive memories. The source material referred to this indirectly through indicators such as reduced responsiveness, a lack of interest in important activities, and avoidance of activities which pull the disturbing occurrence into one's mind. Avoidance manifests in two primary ways: external avoidance and internal avoidance.

External avoidance includes consciously steering clear of places, people, conversations, activities, objects, or situations that might serve as reminders of the traumatic event. For instance, a soldier might avoid parades or loud noises, while a car accident survivor might avoid driving or specific intersections. Internal avoidance involves attempts to suppress distressing thoughts, feelings, or memories related to the trauma. This often results in the reduced responsiveness or emotional detachment noted in the older diagnostic criteria, where individuals appear distant from other people. This emotional numbing, while serving to protect the individual from immediate pain, also severely limits their ability to engage authentically in relationships and experience positive emotions, leading to feelings of profound distance and isolation.

5. Key Symptom Cluster III: Negative Alterations in Cognition and Mood

A defining feature of the disorder, particularly emphasized in the DSM-5, is the development of negative alterations in cognition and mood, often arising or worsening after the traumatic event. This cluster includes an inability to remember important aspects of the trauma (dissociative amnesia), persistent and exaggerated negative beliefs about oneself or the world (e.g., "I am bad," or "The world is completely dangerous"), and distorted cognitions about the cause or consequences of the traumatic event, often leading to self-blame or blaming others.

This domain also encapsulates the negative emotional shifts, such as persistent negative emotional states, diminished interest or participation in significant activities--often correlated with the reduced responsiveness described in the source material--and feelings of detachment or estrangement from others. Furthermore, chronic negative alterations make it difficult to experience positive emotions, contributing significantly to high rates of comorbidity with major depressive disorder. The concept of **survivor's guilt**, specifically mentioned in the source material, falls within this cognitive cluster, reflecting persistent, distorted thoughts regarding one's role in the event or the perceived injustice of having survived when others did not.

6. Key Symptom Cluster IV: Alterations in Arousal and Reactivity

The third major indicator cluster noted in the DSM-IV-TR, described as continual physiological excitation, corresponds to the DSM-5 cluster focusing on marked alterations in arousal and reactivity. This includes irritability and aggressive behavior, reckless or self-destructive behavior, hypervigilance, exaggerated startle reaction, disrupted sleep, and trouble concentrating or

ARABPSYCHOLOGY.COM

remembering. These symptoms indicate a state of chronic physiological stress and hyperarousal, where the body's 'fight or flight' response remains constantly activated, even in safe environments.

The **exaggerated startle reaction** is a classic manifestation, where sudden noises or movements trigger an extreme physical reaction far beyond what is typical. Hypervigilance refers to an excessive scanning of the environment for threats, making it difficult for the individual to relax or feel secure. The combination of chronic hyperarousal and disrupted sleep patterns significantly impairs daily functioning, cognitive capacity, and overall quality of life. This continual physiological load contributes to long-term health problems and maintains the heightened state of readiness that prevents the nervous system from returning to a baseline state of calm following the trauma.

7. Treatment Modalities and Significance

The significance of recognizing PTSD lies in its treatability and profound impact on public health, particularly among populations exposed to organized violence, such as soldiers returning from war, as exemplified by the phrase, "Many soldiers returning from war suffer from PTSD." Effective treatments are primarily psychotherapeutic and pharmacological. Gold-standard psychological treatments include **Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT) and **Eye Movement Desensitization and Reprocessing** (EMDR). These approaches focus on processing the traumatic memory and challenging the maladaptive cognitions and avoidance behaviors that sustain the disorder. Pharmacological interventions, primarily certain types of antidepressants (SSRIs), are often used to manage associated symptoms such as depression, anxiety, and sleep disruption, though psychotherapy remains the first-line treatment.

8. Debates and Criticisms

Debates surrounding PTSD often center on its diagnostic boundaries and cultural universality. Historically, the criticism arose that the criteria were overly focused on combat trauma, potentially pathologizing normal reactions to extreme stress experienced in civilian life. Furthermore, some critics argue that the concept of PTSD medicalizes suffering that should be understood in its social or political context, potentially reducing complex societal issues to individual pathology. There is also ongoing debate regarding the specificity of the symptom clusters, with significant overlap existing between PTSD and other conditions like Major Depressive Disorder and Borderline Personality Disorder, leading to challenges in differential diagnosis. The addition of the dissociative subtype in the DSM-5 attempted to address complex trauma presentations, but discussions continue regarding how best to classify chronic, repeated trauma (often termed "Complex PTSD" or C-PTSD) which involves relational and developmental disruptions beyond the scope of a single event definition.

ARABPSYCHOLOGY.COM

Further Reading

U.S. Department of Veterans Affairs: National Center for PTSD
American Psychiatric Association (APA) - DSM-5 Resources
Post-traumatic stress disorder (Wikipedia)

ARABPSYCHOLOGY.COM