This issue on posttraumatic stress disorder coincides with the tenth anniversary of the Sept. 11 attacks. The direct psychiatric effect and the indirect cultural effect of those attacks, and the two subsequent wars, have led to a vast increase in the posttraumatic stress disorder literature. Although no single issue can summarize all of the developments in this area, we look at this disorder from several different vantage points, helping readers understand the many facets of this common but often misunderstood diagnosis.

Because the term “trauma” is incorporated into the very title of this disorder and because this term is used in lay language to describe a broad and often vague array of experiences, an important starting point for understanding posttraumatic stress disorder (PTSD) is to understand Criterion A for PTSD in The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), which defines what kind of exposure to trauma is necessary to diagnose PTSD. Drs. Surís and North (see page 391) review trauma exposure and its relationship to PTSD in combat veterans, valuable to clinicians for both their clinical practices and reading of research studies. Dr. Binder and colleagues (see page 396) provide a useful contrast to this with an examination of a very different population with true Criterion A exposure: fathers whose newborns are admitted to a neonatal intensive care unit.

The remaining articles shift the focus from exposure to trauma, to the subsequent pathology: Dr. Graf and colleagues (see page 403) examine the “gray zone” between PTSD and personality disorders through the lens of a responder to the Sept. 11 attack in New York City. Dr. Brodman and colleagues (see page 408) examine the effect of PTSD on neurocognition, and Dr. Rasyidi’s Resident’s Viewpoint column (see page 416) discusses the concept of complex PTSD as a way to understand phenomenology that may resemble personality disorders.

This array of views should make readers acutely aware that although PTSD is placed only under the anxiety disorder section in DSM, it is an oversimplification to think of this disorder as simply a problem with anxiety. Instead, this new wave of research focuses on the complex interaction between the type of exposure, the patient’s history of prior trauma, the patient’s underlying personality structure, and the patient’s capacity to process information.

In this tangle, it is often difficult to separate cause from effect or to determine what level of dysfunction should be the primary frame for treatment. However, similar the Akira Kurosawa film, Rashomon (which shows a broad array of reactions to life-threatening trauma), I hope that this set of articles will help you discover truths about PTSD through varying perspectives that are often difficult to reconcile.

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