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Gergen, K. J. (1994). *Realities and relationships: Soundings in social construction.* Cambridge, MA: Harvard University Press.

Gergen, K. J., & Shotter, J. (Eds.). (1994). *Texts of identity.* Thousand Oaks, CA: Sage.

Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation and subjectivity.* New York: Methuen. An important early attempt to apply poststructuralist and postmodern theories to psychological inquiry.

Jameson, F. (1991). The cultural logic of late capitalism. In *Postmodernism: Or the cultural logic of late capitalism* (pp. 1–154). Durham, NC: Duke University Press. Relates the rise of postmodern cultural movements to the globalization of late capitalism.

Kvale, S. (Ed.). (1994). *Psychology and postmodernism.* Thousand Oaks, CA: Sage.

Leary, D. E. (Ed.). (1990). *Metaphors in the history of psychology.* Cambridge, UK: Cambridge University Press. Studies by postmodernists and others of how metaphors have shaped psychological knowledge.

Lyotard, J.-F. (1984). *The postmodern condition: A report on knowledge* (G. Bennington & B. Massouri, Trans.). Minneapolis: University of Minnesota Press.

Potter, J., & Wetherell, M. (1987).*Discourse and social psychology.* Thousand Oaks, CA: Sage.

Sampson, E. E. (1993). *Celebrating the other: A dialogical account of human nature.* New York: Harvester Wheatsheaf.

Suzanne R. Kirschner

POSTSECONDARY EDUCATION. *See* College Teaching and Learning; *and* Technical and Professional Education.

POSTTRAUMATIC STRESS DISORDER. Although symptoms of posttraumatic stress disorder (PTSD) have long been recognized, it was not until 1980 that PTSD was formally defined and classified by the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). PTSD is classified as an anxiety disorder that develops in some individuals after exposure to an extremely traumatic event(s). For an individual to be diagnosed with PTSD, the traumatic event(s) experienced or witnessed must involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others. A response of intense fear, helplessness, or horror at the time of the event(s) must also be involved, although in children the response may be expressed instead by disorganized or agitated behavior. The disorder may occur in individuals who have experienced a broad range of traumatic events. Common examples include combat veterans, crime victims (e.g., rape, assault, robbery, or sexual abuse), prisoners of war, accident victims, survivors of major natural disasters, and those diagnosed with life-threatening illnesses. Lifetime exposure to such traumatic events appears to be common in community-based samples (36–86%), and the likelihood of developing PTSD increases as the intensity of the traumatic stressor increases.

Three symptom clusters (reexperiencing, avoidance/numbing, and hyperarousal) describe the clinical features of PTSD. First, the traumatic event is persistently reexperienced. Intrusive and disruptive memories of the trauma are common, as are frightening dreams or nightmares. Some individuals experience dissociative states (flashbacks) that last from a few seconds to a few hours, during which the traumatic event is relived. In rare cases, the individual may even behave as though experiencing the traumatic event again at that moment. Exposure to environmental stimuli that resemble an aspect of the traumatic event often evokes intense psychological distress and/or physiological reactivity. For example, combat veterans often become highly upset when they hear fireworks that remind them of gunfire, and they may notice their heart racing as if they were back in combat. Young children with PTSD may not necessarily have the sense that they are reliving their traumatic past, but rather may reexperience their trauma in symbolic ways. For example, they may exhibit general nightmares (e.g., frightening monsters), repetitive play (e.g., reenacting the trauma with toy figures), or somatic symptoms (e.g., headaches and stomachaches).

Second, such reexperiencing and reactivity leads to persistent avoidance of cues associated with the traumatic event. This includes efforts to avoid thoughts, feelings, or conversations about the trauma, as well as efforts to avoid activities or situations that arouse recollections of the trauma. On rare occasions, this avoidance may include amnesia for significant aspects of the trauma. Reduced emotional responsiveness to the external world is also common, with many individuals reporting decreased interest in activities they previously enjoyed, feeling detached or cut off from other people, or having reduced ability to feel emotions (especially those associated with love, happiness, joy, and sexuality). They may also experience a sense of a foreshortened future, as if they do not expect to have a career, marriage, or normal life span.

Third, persistent symptoms of increased arousal or anxiety that were not present before the trauma also cause disruption in the lives of those with PTSD. These symptoms include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle response.

Finally, for a diagnosis of PTSD, the disturbance must last for at least 1 month and it must cause sig-

nificant distress or impairment in social, occupational, or other important areas of functioning. It merits comment that many PTSD symptoms, such as impaired concentration, sleep disturbance, irritability, social avoidance, and sense of a foreshortened future are also found in other disorders (e.g., depression and anxiety). What seems to distinguish PTSD from other mood or anxiety disorders are the reexperiencing of symptoms (nightmares, flashbacks), physiological reactivity to trauma cues, and avoidance of trauma cues. There is also a distinct set of neurobiological markers that differentiates PTSD from other affective and anxiety disorders in laboratory studies, notably, changes on the hypothalamic-pituitary-adrenal axis.

Associated Disorders and Features

A distinct set of secondary symptoms, associated features, and concurrent psychiatric disorders are commonly found among those with PTSD. These individuals may experience strong feelings of guilt and shame, often related to having survived when others did not, to the things they did in order to survive, or to the belief that they allowed themselves to be victimized. In addition, a broad range of interpersonal problems are typically associated with PTSD. Many individuals with PTSD often feel misunderstood, alienated, and detached from others. Therefore, they may feel lonely and isolated from friends, family members, and society as a whole. Complicating matters is the finding that irritability, anger control deficits, interpersonal communication skill deficits, social anxiety, and social avoidance are commonplace. Thus, PTSD symptoms and the phobic avoidance of activities or situations that represent the trauma may interfere with interpersonal relationships and occupational functioning.

Studies examining physiological reactivity in trauma victims with PTSD have consistently found heightened reactivity to trauma-related cues as compared to trauma victims without PTSD. In these studies, trauma-related audio visual cues (sounds or pictures) or individually tailored script-driven imagery are presented while physiological responses such as blood pressure (BP), heart rate (HR), galvanic skin response (GSR), or forehead electromyogram (EMG) are measured. Trauma victims diagnosed with PTSD produce significantly larger BP and HR responses during cue exposure than do trauma victims without PTSD, although EMG and GSR have been less reliable in differentiating these groups. There is evidence that measurement of physiological reactivity may provide relatively good discrimination even when individuals are attempting to fake their responses. Interestingly, no differences have been found in general autonomic reactivity to nontraumatic cues between those with and without PTSD. Thus, the reactivity in those with PTSD appears to be elicited only in response to specific trauma-related cues.

Finally, there is typically a high prevalence of other psychiatric disorders in both civilians and combat veterans with PTSD. Acute concomitant disorders often include substance abuse, major depression, dysthymia, sexual dysfunction, and other anxiety disorders. Although rates for these disorders vary depending on the trauma population examined and the evaluation procedures used, studies have reported rates of concurrent mental disorders ranging as high as 80 to 100%. Personality disorders are also frequently diagnosed in PTSD populations, including borderline, schizoid, avoidant, and antisocial personality disorders. At present, the extent and nature of personality disorders in individuals diagnosed with PTSD is not well understood, and it is not clear whether trauma changes personality or if certain personality patterns predispose some towards traumatic experiences and/or PTSD. There is some evidence to provide partial support for both possibilities.

Prevalence and Course of PTSD

Epidemiological estimates of PTSD vary somewhat, depending on the method of evaluation and the population sampled, although most community-based studies indicate a lifetime prevalence ranging from 1 to 14%. Among traumatized populations, the percentage with PTSD is higher. It has been estimated that 9 to 31% of combat veterans have a lifetime history of PTSD, with current rates of the disorder ranging from 6 to 26%, depending on the particular war. African American, Hispanic, and Native American veterans have been shown to have higher absolute rates of PTSD than Caucasian veterans, although this difference disappears when factors such as premilitary trauma and degree of combat exposure are taken into consideration. For civilian crime victims, lifetime rates range from 18 to 28%, with current rates ranging from 5 to 11%.

Symptoms of PTSD can occur at any age, including early childhood, following the experience of trauma. Although symptoms are usually apparent within several weeks or months of the traumatic experience, there may be delayed onset of months or years before the symptoms appear. Duration of this disorder varies greatly, although approximately half of those developing it achieve full recovery without treatment within 3 months of symptom onset. However, in some cases symptoms are long lasting. For example, many veterans are still suffering severe and debilitating symptoms from wars fought more than 50 years ago (e.g., World War II). There is some evidence that social support, family history, childhood experiences, and personality variables may influence the development of the disorder, although it appears that PTSD can develop in anyone if the traumatic stress is severe enough.

Treatment of PTSD

At this point, PTSD treatment is still in the early stages of development, which is not surprising, given that formal recognition of the disorder is relatively recent (1980). A wide range of psychosocial and pharmacological treatments have been used with PTSD. However, there is surprisingly little research to indicate which treatments are most effective, and there is little general consensus among clinicians about which treatments should be used. Cognitive-behavioral treatments have been the most widely studied psychosocial interventions and include strategies such as exposure therapy (e.g., flooding and systematic desensitization), stress inoculation, cognitive processing therapy, anger management, social skills training, and relaxation training. The clinical efficacy of these interventions has been partially demonstrated, although the manner in which they can be most effectively implemented and combined with other treatments is still under investigation. Other common psychosocial treatments include psychodynamic, family, and marital therapy, peer-counseling groups (e.g., "rap" groups), and psychiatric inpatient settings. Pharmacological treatments have focused on the use of psychotropic medications (e.g., antidepressants and antianxiety agents) to reduce symptoms of depression, anxiety, and hyperarousal, as well as to help regulate the sleep cycle. However, there are few empirical data to guide psychiatrists in the prescription of these medications with PTSD patients, and no medication has been designed specifically for PTSD. In short, although some extant treatments have demonstrated clinical efficacy, we currently do not have a "cure" for the disorder, but rather view treatment strategies as ways to help manage the symptoms and improve quality of life.

[*See also* Combat; *and* Rape.]

Bibliography

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Davidson, J. R. T., & Foa, E. B. (Eds.). (1993). *Posttraumatic stress disorder: DSM-IV and beyond.* Washington, DC: American Psychiatric Press.

Foa, E. B., & Riggs, D. S. (1995). Posttraumatic stress disorder following assault: Theoretical considerations and empirical findings. *Current Directions in Psychological Science, 4*, 61–65.

Foy, D. W. (Ed.). (1992). *Treating PTSD: Cognitive-behavioral strategies.* New York: Guilford Press.

Freedy, J. R., & Hobfall, S. E. (Eds.). (1995). *Traumatic stress: From theory to practice.* New York: Plenum Press.

Friedman, M. J., Charney, D. S., & Deutch, A. Y. (Eds.). (1995). *Neurobiological and clinical consequences of stress: From normal adaptation to PTSD.* Philadelphia: Lippincott-Raven.

Frueh, B. C., Turner, S. M., & Beidel, D. C. (1995). Exposure therapy for combat-related PTSD: A critical review. *Clinical Psychology Review, 15*, 799–817.

Giller, E. L. (Ed.). (1990). *Biological assessment and treatment of posttraumatic stress disorder.* Washington, DC: American Psychiatric Press.

Keane, T. M., & Wolfe, J. (1990). Comorbidity in posttraumatic stress disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology, 20*, 1776–1788.

Kulka, R., Schlenger, W., Fairbank, J., Hough, R., Jordon, B., Marmar, C., & Weiss, D. (1990). *Trauma and the Vietnam war generation.* New York: Brunnel/Mazel.

Shalev, A. Y., Bonne, O., & Eth, S. (1996). Treatment of posttraumatic stress disorder: A review. *Psychosomatic Medicine, 58*, 165–182.

B. Christopher Frueh

POVERTY. [*This entry provides a broad survey of poverty. It is chronologically divided into two articles:* Childhood Poverty *and* Adulthood Poverty.]

Childhood Poverty

The term *poverty* typically is used to refer to economic deprivation that results when income is insufficient to meet basic needs. It is commonly defined by cash income using the official federal poverty threshold as a marker. Developed in 1965 by Mollie Orshansky, an economist employed by the Social Security Administration, the poverty threshold was officially adopted by the government in 1969 to highlight the existence of poverty, to establish the need for antipoverty policies, and to provide an indicator of progress in the fight against poverty. It was originally based on the estimated cost of food (a very basic diet) multiplied by three, a formula adopted on the basis of a household budget study conducted in 1955 indicating that families typically spent about one third of their post-tax household income on food. The poverty threshold is adjusted annually for family size and inflation, but not for geographic region or noncash benefits (e.g., food stamps).

Although the validity of this index has been questioned on many grounds, it is widely used in both research and policy. Two points are important: First, it is an absolute dollar amount, not a percentage of the median income or a percentile. Therefore, it is theoretically possible for everyone to be above the poverty threshold. Second, it does not reflect how far below (or above) the threshold people fall (i.e., the poverty gap). Increasingly, researchers studying the effects of childhood poverty measure the poverty gap by computing an income-to-need ratio (calculated as household income/official pov-