Chapter 1

Post-traumatic stress: the history of a concept

Introduction

This chapter describes how, throughout history, writers and historians have recognised that following exposure to extreme stress and trauma, people may develop long-term emotional and psychological responses. However, this view took a long time to become established in psychiatry and as late as the nineteenth century there were few psychiatrists who accepted the notion that fear and horror were sufficient to cause a psychological disorder. The experience of dealing with dead and injured soldiers in the First World War provided the background and impetus to the development of new ideas on the origins of psychological trauma. This increase in knowledge has led to the development of a classification of post-traumatic stress disorder (PTSD) that is accepted throughout the world.

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Trauma in literature

The idea that people can develop physical and psychological disorders following an exposure to a traumatic event that caused them fear or horror rather than a physical injury is not new. Literature has provided us with a rich source of powerful accounts of the human responses to war, murder, rape and other personal disasters. Authors such as Homer in the *Iliad* and Shakespeare in *Henry IV* and *Macbeth* create central characters whose dramatic symptoms and behaviours would today be diagnosed as indicative of post-traumatic stress (Trimble 1981).

Graphic descriptions of human responses to disasters, accidents and wars can be found in many historical documents (Trimble 1985). Samuel Peyps' *Diary* provides a good example of psychological

trauma induced by a disaster. In Peyps' case, the disaster was the Great Fire of London, which occurred in September 1666. Pepys described his feelings as the fire spread towards his home and gave a vivid description of the terror experienced by the citizens of the city, unable to protect their homes and property from destruction. Six months later Peyps writes of his difficulty in sleeping due to nightmares caused by his experience of the fire and his panic at the news of a chimney fire some distance away (Daly 1983). The author Charles Dickens was a passenger on a train that crashed at Staplehurst in Kent in July 1868. In a letter to a friend, Dickens described his distress at being trapped for several hours surrounded by dead and dying passengers. Following the incident Dickens developed a phobia about travel by rail and described himself as 'not quite right within' and as 'curiously weak – weak as if I were recovering from a long illness' (Forster 1969).

Wars over the centuries have affected millions of people. In an account of life in the trenches in the First World War a soldier (Fred White of the 10th Battalion King's Royal Rifle Corps) said:

> It took years to get over it. Years! Long after, when you were working, married, had kids, you'd be lying in bed and you'd see it all before you. Couldn't sleep. Couldn't lie still. Many and many's the time I've got up and tramped the streets till it came daylight. Walking, walking – anything to get away from your thoughts . . . That went on for years, that did.
>
> (MacDonald 1988)

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The nineteenth-century view of trauma

In contrast to wide recognition in literary works, medicine and psychiatry were resistant to the view that traumatic emotional experiences can profoundly and permanently alter a person's psychology and physiology (Van der Kolk *et al.* 1996). If a physician of the nineteenth century were to be asked what caused traumatic shock, the most likely response would be that it was due to organic damage to the nervous system. Most physicians of the time rejected any suggestion that an individual's perception or beliefs about a traumatic event were capable of bringing about the magnitude of change in the functioning of the brain that could result in a psychiatric disorder. The common belief of the time was that concussions to the head, injuries to the spinal cord or small cerebral haemorrhages alter

psychic functioning, thereby causing the psychological symptoms (Trimble 1985). An example of the views of the time comes from Herman Oppenheim who said, 'functional problems are produced by molecular changes in the central nervous system, any suggestion that these difficulties could have an origin in an individual's perceptions of a traumatic event is incorrect' (Oppenheim 1889). This belief regarding the physical origins of psychological symptoms resulted in a proliferation of terms being used to describe a psychological disorder relating to specific experiences of the victim. Examples of some of the most common diagnoses of the time included 'spinal concussion', 'railway spine', 'irritable heart', 'soldier's heart' and 'shell shock' (Parry Jones and Parry Jones 1994). The giving of different names to what appeared to be the same condition was slowly challenged and by the end of the nineteenth century attempts were made to utilise the single diagnosis of 'traumatic neurosis' (Seguin 1890).

During the same period, the French neurologists Charcot and Janet were developing a second challenge to the traditional physicist view (Van der Kolk *et al.* 1996). Janet had painstakingly observed his traumatised patients and discovered that they tended to react to reminders of their trauma with responses that were more relevant to the original traumatic threat than to their current situation. Janet also found that these patients had difficulty in integrating the traumatic experience with their earlier life experiences, and consequently sometimes entered dissociative states as a way of dealing with these distressing memories. The work of Janet had a profound effect on Breuer and Freud. In *Studies on Hysteria* they said, 'hysterics suffer mainly from reminiscences, the traumatic experience is constantly forcing itself upon the patient and this is proof of the strength of that experience: the patient is, as one might say, fixated on his trauma' (Breuer and Freud 1955). Freud's views on the impact of actual traumatic events were overtaken by his beliefs about the importance of repressed infantile sexuality. Consequently, he never pursued any investigations of the real traumatic events that had occurred to his patients, preferring to concentrate on the Oedipal crisis that he believed occurred in early childhood.

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The First World War

The First World War exposed large numbers of soldiers to trauma, and provided doctors and physicians with extensive experience in

dealing with traumatic stress. This exposure brought about an increased awareness of the psychological aspects of the traumatic experience and caused many physicians to question whether physical injuries had any impact on psychiatric disorders. While some psychiatrists continued to cling to the notion that physical injuries were the *cause* of psychological disorder (e.g. Mott 1919), others rejected this approach. This dramatic change of view is illustrated by Charles Myres who had introduced the diagnosis of shell shock (Myres 1915) but went on to find that many soldiers exhibited the symptoms of shell shock without coming under fire. Myres wrote, 'my term shell shock is misleading . . . the true cause of the soldier's problems is the shock and horror of war' (1940).

Some of the resistance to the idea that soldiers could suffer a psychiatric disorder without any physical injury can be found in the Public Records Office in Kew, London. In the First World War, a number of soldiers were shot for cowardice. The documents relating to these men strongly suggest that many were suffering from post-traumatic stress, and yet it is clear that those making the decision as to which soldiers should be shot for cowardice and which needed treatment preferred an approach that used objective evidence such as a 'lesion of the brain' or 'damage to the heart', rather than the subjective judgements of psychiatrists on the soldiers' psychological symptoms (Moran 1945).

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After the First World War, several war psychiatrists, experienced in dealing with the psychological impact of war trauma, left the forces and returned to civilian life. These psychiatrists recognised that civilian patients, who had been the victims of accidents or disasters, had symptoms similar to those they had seen on the battlefield (Merskey 1991). Unfortunately, there was little support for the view of these war psychiatrists that there was a 'common trauma syndrome'. One notable exception to this was Abram Kardiner. Kardiner began his career treating US war veterans. After leaving the army, he studied psychoanalysis with Freud. In the light of the knowledge and insights gained with Freud, Kardiner re-analysed his extensive clinical data on war veterans. The results of the re-analysis were published in *The Traumatic Neurosis of War* (Kardiner 1941), which provided a detailed analysis of a psychological trauma syndrome which he named 'psychoneurosis'.

The essential features of psychoneurosis were:

- persistence of startle response and irritability;

- proclivity to explosive outbursts of aggression;
- fixation on the trauma;
- constriction of general level of personality functioning;
- atypical dream life.

Kardiner claimed that war created a single syndrome, psychoneurosis, and that this syndrome was essentially the same as traumatic neurosis, the syndrome of civilian life. (Kardiner 1941). His views provided a challenge to the American Psychiatric Association to address the confusion caused by the multitude of terms used to describe the same psychological conditions.

Recognition of traumatic stress

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The American Psychiatric Association commissioned the development of a manual to provide a codification and classification of mental disorders. The first edition (American Psychiatric Association 1952) provided internationally acceptable statistical and diagnostic data which supported a classification of mental disorders. One of the psychiatric categories in this first edition of the manual (*DSM I*) was 'gross stress reaction', an acute reaction to extreme stress. The characteristics of gross stress reaction were similar to those for psychoneurosis apart from an additional situational precondition: 'the impact of the event to be so serious that it would have evoked overwhelming fear in any so-called normal person'. Strangely, the second edition of the manual (*DSM II*) removed gross stress reaction (American Psychiatric Association 1968). In the third issue of the *Manual* in 1980 (*DSM III*) the syndrome re-emerged, this time under a new name: 'post-traumatic stress disorder' (PTSD) (American Psychiatric Association 1980). In the most recent issue of the *Manual*, *DSM IV* (American Psychiatric Association 1994) there are six criteria relating to PTSD. The first describes the traumatic situation, the next three the trauma symptoms and the last two the duration and effect of the symptoms on the person's personal life and work (see Table 1.1)

One might expect that the status of post-traumatic stress would be well established among the medical and psychological researchers and practitioners of the twenty-first century. While this is generally true, there are still groups of psychiatrists who do not accept the existence of post-traumatic stress. An example is the assertion that 'traumatic life experiences do not cause a psychological disorder any

Table 1.1 *DSM IV* diagnostic criteria for post-traumatic stress

Criterion A: the person has been exposed to a traumatic event in which both of the following were present:

1 The person experienced, witnessed, or was confronted by an event(s) that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others.
2 The person's response involved intense fear, helplessness or horror.

Criterion B: the traumatic event is re-experienced in one or more of the following ways:

1 Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.
2 Recurrent distressing dreams of the event.
3 Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
4 Intense psychological distress at exposure to internal and external cues that symbolise or resemble an aspect of the traumatic event.
5 Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

Criterion C: persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:

1 Efforts to avoid thoughts, feelings.
2 Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3 Inability to recall an important aspect of the trauma.
4 Marked diminished interest or participation in significant activities.
5 Feeling of detachment or estrangement from others.
6 Restricted range of affect (e.g. unable to have loving feelings).
7 Sense of foreshortened future (e.g. does not expect to have a career, marriage or normal life).

Criterion D: persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

1 Difficulty in falling or staying asleep.
2 Irritability or outbursts of anger.
3 Difficulty concentrating.
4 Hypervigilance.
5 Exaggerated startle response.

Criterion E: duration of disturbance is more than one month.

Criterion F: the disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

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more than life events cause depression' (Wessley 2000). There is a rather more serious debate on whether the restrictions in Criterion A (see Table 1.1) are too limiting. The situation created by *DSM IV* is that if an individual cannot demonstrate actual exposure to a situation which meets Criterion A, post-traumatic stress cannot be diagnosed. A number of researchers have expressed concerns over the use of Criterion A as a precondition for PTSD (Duckworth 1987; Ravin and Boal 1989). There is mounting clinical evidence (Scott and Stradling 1992b; Leymann and Gustafsson 1996) that chronic exposure to stressful conditions including organisational bullying and extreme pressure at work can lead to symptoms which are indistinguishable from those caused by a single traumatic event. If the key diagnostic feature of traumatic stress is symptoms, then *prolonged duress stress disorder* (PDSD) (Ravin and Boal 1989; Scott and Stradling 1992b) and *disorders of extreme stress not otherwise specified* (DESNOS) (Herman 1993) should be regarded as traumatic stress disorders. If, on the other hand, the diagnosis of traumatic stress retains the precondition of the Criterion A situational characteristics, then PDSD and DESNOS cannot be regarded as PTSDs.

International classification of diseases

While *DSM IV* has been influential in providing a recognised classification system, there is another system which is also in common use. The World Health Organisation included the category of PTSD in its most recent edition of the *International Classification of Diseases*, *ICD 10* (World Health Organisation 1993). Within this category, *ICD 10* describes three diagnoses: *acute stress reaction*, *adjustment disorder* and *PTSD*.

Acute stress reaction describes a transient disorder that develops without any other mental disorder. Symptoms of the acute stress reaction appear within minutes of the traumatic exposure, waning within hours. Adjustment disorder refers to states of subjective and emotional disturbance that arise in the period of adaptation to a significant life change or stressful event. Symptoms usually begin within one month of the occurrence of the stressful event and rarely exceed six months.

The diagnostic criteria of PTSD outlined in *ICD 10* are similar to those in *DSM IV* and involve the identification of a stressor which has the magnitude to cause the onset of the disorder. However, the process of making a diagnosis is different. The *ICD* approach

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recognises that other factors such as a pre-existing disorder or a vulnerable personality may play a role in the development of PTSD, but that these factors are neither necessary nor sufficient to explain its occurrence. The major difference between *ICD 10* and *DSM IV* is that *ICD 10* states that although emotional numbing is a common feature of the disorder it is not necessary for a diagnosis. (Joseph *et al.* 1997). The *ICD 10* diagnostic criteria for post-traumatic stress are as follows:

> This disorder should not generally be diagnosed unless there is evidence that it arose within six months of a traumatic event of exceptional severity. A 'probable' diagnosis might still be possible if the delay between the event and the onset was longer than six months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. such as anxiety or obsessive-compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery or dreams. Conspicuous emotional detachment, numbing of feelings and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbance, mood disorder, and behavioural abnormalities all contribute to the diagnosis but are not of prime importance.
>
> (World Health Organisation 1993)

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Discussion

It is important for workers in the field of post-traumatic stress to have some understanding of the history and development of the concept. The fact that the diagnostic criteria have taken over 100 years to evolve and the likelihood of further revisions in the next *Diagnostic and Statistical Manual* is evidence of the interest and active research in the area. The history of the development of the concept of post-traumatic stress clearly illustrates the value of clinical experience and the detailed observation of individual cases, which frequently contradicts and challenges existing knowledge and provides an important impetus for change. The *Diagnostic and Statistical Manual* has recognised these changes and developments by integrating the latest theoretical and clinical knowledge within a defensible codification. Whether Criterion A will be amended in

future editions of the manual or new classifications created to include people whose PTSD-like symptoms result from chronic or prolonged duress rather than an acute trauma is a matter for further research and debate (Scott and Stradling 1992b).

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