Posttraumatic Stress Disorder Part I: Historical Development of the Concept

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TOPIC. Posttraumatic Stress Disorder (PTSD) is a significant health problem, characterized by high rates of chronicity and comorbidity.

PURPOSE. This is the first of three articles examining the sufficiency of the current PTSD construct to articulate the spectrum of human responses to trauma, in particular as it relates to women and interpersonal trauma. This paper reviews the conceptual history of PTSD from the nineteenth century up to its inclusion in the DSM-III (American Psychiatric Association, 1980).

SOURCES OF INFORMATION. Existing bodies of theoretical and research literature related to the effects of trauma.

CONCLUSION. Although there is strong evidence that gender plays a role in responses to stress and trauma, gender specificity is not well-incorporated into clinical services or research in the area of PTSD.


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While historical and literary references to the after-effects of psychological trauma date as far back as the third century BC (Birmes, Hatton, Brunet, & Schmitt, 2003), official sanction of posttraumatic stress disorder (PTSD) as a psychiatric diagnosis occurred only 26 years ago. In 1980, amid controversy that lingers even today, the American Psychiatric Association (APA) included PTSD in the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The significance of this act cannot be overstated. First, it named the residual effects of horrific life events and created a conceptual framework for the systematic study of trauma and its sequelae. Second, it stipulated that an external agent (i.e., a traumatic event) rather than some inherent weakness within the individual was critical to the development of the disorder (Friedman, n.d.). Third, the formal declaration of the potentially serious and long-lasting responses to trauma validated and legitimatized the experiences of affected individuals. Finally and perhaps most importantly, the construct of PTSD contributed “a model for correcting the decontextualized aspects of today’s psychiatric nomenclature” (Van der Kolk & McFarlane, 1996, p. 5). It did so by endorsing the notion that individuals exist within a unique environmental context and that through continuous and reciprocal interaction, the individual and the environment influence and are influenced by each other. The significance of this stance is that it encourages healthcare providers to approach the person-in-context holistically and to view “disorders” as embodied human experiences.

The overall aim of this three-part series is to examine the sufficiency of the current PTSD construct in articulating the full spectrum of human responses to trauma. It argues for the necessity of significantly increasing gender-based perspectives in all health
research and service delivery, particularly as it relates to interpersonal trauma (sexual, physical, and/or emotional abuse) among women. As Kimerling, Ouimette, and Wolfe (2002) point out, a gendered perspective transcends biology and advocates an ecological stance as being fundamental to understanding differing patterns of health and illness between men and women. Such a framework locates biologically based sex differences within a historical, social, cultural, political, and economic context. In trauma studies, this has the potential to account “for intragender diversity as well as [for] differences between genders by assuming that gender differences are context-dependent” (p. xii). Other studies in both the psychosocial (Addis & Carpenter, 1999; Blair-West & Mellsop, 2001; Klonoff, Clark, Horgan, Kramer, & Mc Dougall, 1976) and biological literatures (Rubinow & Schmidt, 1996; Seeman, 1997) also support the need for gender-specific health research. The Report on Mental Illness in Canada (Health Canada, 2002) highlighted the need to include sex and gender issues as a research priority.

Although there are data suggesting gender differences in responses to trauma, gender is not systematically included across trauma studies, thus making cross-study comparisons and interpretations difficult. For example, we know from epidemiological studies that the lifetime prevalence of exposure to traumatic events is higher among men. However, the risk of developing PTSD among those exposed is approximately twofold higher in women (Breslau, 2002; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). A number of vulnerability factors have been proposed to account for this sex differential, including women’s greater likelihood of exposure to assaultive violence, societal influences, the meanings ascribed to traumatic experiences and hormonal influences. Women with histories of interpersonal trauma often experience a characteristic cluster of symptoms dubbed “complex” PTSD.

An understanding of the limitations of the current DSM-IV-TR PTSD (APA, 2000) construct in explaining women’s response to interpersonal trauma has its roots in the nineteenth century. This article briefly reviews the evolution of PTSD within the DSM nosology. As well as providing context for understanding past and current issues in the study of human responses to trauma, it chronicles refinements to the original construct in response to a growing body of empirical research. Part II in the series describes the evolution of PTSD as a diagnostic construct within the DSM nosology, while Part III examines gender differences in responses to trauma. The latter also considers evidence that supports the existence of a more complex post-traumatic stress syndrome characteristic of trauma involving significant differences in power and control.

The History of PTSD in the Clinical Literature

As observers and scribes of the human experience, the literati are the stewards of our collective memory. Their works are invaluable to us as enduring repositories of

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facts and details about important events, but also because they inform us about the meaning and consequences of those events to individuals and social groups. An example of this is the body of literature that documents human responses to traumatic events. From antiquity onward, historians and writers of every ilk have expressed an unwavering understanding that exposure to terrifying and life-threatening events such as war, torture, physical and sexual assault, natural disasters, and accidents leaves a lasting impression on the human mind, body, and soul (Birnes et al., 2003; Van der Kolk, Weisaeth, & Van der Hart, 1996). In contrast, the psychiatric literature has not been as straightforward. As Judith Herman (1997, p. 7) observes,

The study of psychological trauma has a curious history—one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later.

Van der Kolk and his colleagues (1996) agree with Herman’s observation and attribute this recurring amnesia to the reluctance by psychiatry to fully accept that external factors can “profoundly and permanently alter people’s psychology and biology” (p. 47). Herman, on the other hand, believes that this pattern of intermittent forgetting reflects the fact that the study of psychological trauma forces us to confront two deeply troubling existential truths—human vulnerability in the natural world and our capacity for evil.

Some of the earliest clinical references to the effects of psychological trauma date back to nineteenth-century Britain, when the technological advances of the Industrial Revolution paralleled the emergence of psychiatry as a medical specialty. At that time, railway cars were flimsy, wooden structures that offered scant protection for their occupants. Train travel was at best uncomfortable (because of the violent rocking of the cars on the tracks) and potentially lethal (because of the high incidence of railroad crashes). Before long, medico-legal issues surfaced concerning the ill effects of this mode of travel on the health of both railway employees and passengers (Cohen & Quintner, 1996). In 1861, Dr. Waller Lewis (as cited in Cohen & Quintner, 1996), physician to Her Majesty’s Post Office, reported a syndrome that he observed among traveling Post Office employees who had been involved in railway crashes. Symptoms of what he called railway spine or postsaccussion syndrome (what today might be termed whiplash or soft tissue injury), included sleep disturbances, nightmares about collisions, tinnitus, intolerance of railway travel, and chronic pain.

Is it the event itself or the subjective interpretation of the event that is the source of the trauma?

Because severe and lasting disability reportedly existed in the absence of external signs of injury or objective signs of neurological damage, distinguishing between individuals whose complaints were genuine and those who feigned injury became a major problem for judges and physicians alike. Some physicians (e.g., Enichsen, 1875) attributed the psychological sequelae of railway spine to organic causes, while others such as Page and Oppenheim believed such problems to be psychological in origin (cited in Lamprecht & Sack, 2002; Van der Kolk et al., 1996). The latter implied either a constitutional frailty or a charlatan attempt to bilk financial compensation from a railway company—or both. In a monograph on the topic, Oppenheim (1889, cited in Weisaeth & Eltinger, 1991) renamed the syndrome traumatic neurosis. Supposedly this was the first time that the word trauma was applied in psychiatry—before that it had been the exclusive purview of surgery.
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It was during these early debates concerning the etiology of railway spine that many fundamental questions about the nature of psychological trauma began to arise. Is the disorder organic or psychological in origin? Is it the event itself or the subjective interpretation of the event that is the source of the trauma? Does the event cause the disorder or is the disorder attributable to an inherent weakness in the individual? Embedded in these questions are larger and more basic questions about the relationship of mind and body, and about the relationship between the individual and their environment. These same queries would resurface as key themes in the clinical trauma literature over the next century (Cohen & Quinlan, 1996; Van der Kolk et al., 1996).

Of particular issue in debates about railway spine—especially when women were involved—was its relationship to hysteria. Hysteria, from the Greek word for womb (Anderson, Anderson, & Glanze, 1994), was a major focus of study in the late nineteenth century (Herman, 1997; Van der Kolk et al., 1996); while poorly defined, the term was widely used in reference to an astounding number of mental and physical ailments. Examples of these included paralyses, tremors and spasms, disorders of sensation including anesthesia and hyperesthesia, and a wide array of disturbances in the respiratory, digestive, and cardiovascular systems that may or may not be accompanied by mental symptoms (Marlowe, 2000). The sheer vastness of the list left Micalet (1889, p. 319) to suggest that the word was a "dramatic medical metaphor for everything that men found to be mysterious or unmanageable in the opposite sex."

Nevertheless, physicians of the day could not help but recognize that many of the symptoms of railway spine were similar to those of hysteria. This further muddied the debate about the etiological origins of both disorders. It also introduced gender as an important theme in the clinical literature on PTSD. As will become apparent later, women and men react to psychological trauma differently for reasons we are only now beginning to understand.

The study of hysteria reached its zenith in late nineteenth-century Europe. One important figure of the day was the French neurologist Jean-Martin Charcot (1887, cited in Weisæth & Birthing, 1991) a man whose professional stature lent sorely lacking credence to the endeavor. As the senior physician at the Salpêtrière hospital in Paris, Charcot carefully observed and documented the symptoms of hysteria among his women patients there. He and a student, Joseph Babinski, concluded that many of the somatic symptoms of hysteria were psychogenic in origin since they could be induced and relieved through hypnosis (Herman 1997; Van der Kolk et al., 1996). This discovery was a critical link between hysteria and what Pierre Janet would later call dissociation (Van der Kolk & Van der Hart, 1989). Janet, another of Charcot’s students, observed that his female patients experienced altered states of consciousness when they were reminded of distressing events from their past, which led him to propose a relationship among hysteria, dissociation, and the emotional distress elicited by memories of past psychological trauma. Janet hypothesized that psychically traumatized individuals are incapable of integrating the memories of painful events and the intense emotions associated with them, into their narrative memory. As a result, both the distressing memory and the accompanying emotions remain dissociated from consciousness. When exposed to stress in their present lives, these individuals react automatically with "somnambulistic crises (agitation and uncontrolled outburst of violence against the self and others), abulia (psychosomatic complaints and chronic behavioral passivity), and dissociative phenomena" (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996).

In Vienna, working independently of Janet, Sigmund Freud and his collaborator Joseph Breuer reached similar conclusions about hysteria. Both groups of men also discovered that many of the symptoms of hysteria could be ameliorated when the traumatic memories and their attendant emotions were integrated and put into words. Janet called his version of this process psychological analysis, while Breuer and Freud called it abreaction or catharsis. Freud later settled on the term psychoanalysis (Herman, 1997).
In 1896, Freud published *The Aetiology of Hysteria*, an inquiry into the origins of hysteria based on 18 case studies. In it, he states that, “At the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis” (p. 203). While this was an important step in linking past psychological trauma with current symptomology, the moral and social implications of Freud’s conclusions proved to be too alarming even to him and within a short while he quietly denounced his hypothesis on the origins of hysteria. This exemplifies Herman’s contention that “the ordinary response to atrocities is to banish them from consciousness” (1997, p. 1).

Other nineteenth-century investigative efforts into psychological trauma were associated with war. This grew out of the observation that soldiers in the throes of active duty frequently exhibited distress characterized by arousal of the cardiovascular system. Arthur Meyers (1870) coined the term soldiers’ heart to describe a disorder that included extreme fatigue, dyspnea, palpitations, sweating, tremors, and occasionally complete syncope often seen among soldiers involved in combat. In the next year, the Spanish-born Jacob Mendez Da Costa (1871), an army surgeon in the American Civil War, elaborated on Meyer’s work. Also called irritable heart, effort syndrome, and DaCosta’s syndrome, the disorder was presumed to be a strictly biological response to the stress of battle (Birmes et al., 2003; Moreau & Zizook, 2002). This explanation was useful in that it furnished an honorable solution for all parties who might be compromised by people breaking down under stress: The soldier preserved his self-respect, the doctor did not have to diagnose personal failure or desertion, and military authorities did not have to explain psychological breakdowns in previously brave soldiers, or bother with such troublesome issues such as cowardice, low unit morale, poor leadership, or the meaning of the war effort itself (Van der Kolk et al., 1996, p. 48).

Interest in the study of trauma waned for a number of years until the horrors of World War I shocked humanity into a renewed awareness of it. In the course of four short years, 8 million people died and the world as it had been was irrevocably changed. For the soldiers themselves, prolonged exposure to the gruesomeness of trench warfare permanently shattered any illusions about the glory and honor of war. Thousands of young men faced the constant threat of their own death and witnessed the mutilation and deaths of their comrades. In response, many of them “began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not move. They became mute and unresponsive. They lost their memory and the capacity to feel” (Herman, 1997, p. 20). The British military psychiatrist Charles Samuel Meyers (1915) coined a new term—shell shock—to describe this phenomenon. Initially he postulated its cause to be cerebral concussions and the rupture of small blood vessels resulting from proximity to exploding shells. When Myers also recognized these symptoms in soldiers not directly engaged in battle he was compelled to distinguish shell concussion (a neurological condition) from shell shock, a psychological malady brought on by exposure to the extreme conditions of war (Lamprecht & Sack, 2002).

Abram Kardiner (1941), whose work would later furnish the basis for the DSM-III (APA, 1980) formulation of PTSD, was an American psychiatrist whose studies with Freud led him to explore psychoanalytic theory as a means to explain what he came to call war neurosis. Kardiner noticed that soldiers suffering from war neuroses often developed amnesia for the traumatic event, while behaving as if they were still in the midst of it. He viewed this combination of amnesia and physiological arousal as being all part of an attempt by the individual to protect their ego integrity. Although he recognized that many of the features of war neuroses mirrored hysteria, he was loath to associate the two words because of the derogatory connotations of the latter.
When the word "hysterical" . . . is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such neurosis is, therefore, without sympathy in court, and . . . without sympathy from his physicians, who often take . . . "hysterical" to mean the individual is suffering from some persistent form of wickedness, perversity, or weakness of will (Kardiner & Spiegel, 1947, p. 1).

At the end of World War I the relationship of psychological trauma to war neurosis and hysteria remained unclear. These and other manifestations of psychological distress were grouped together under the broad rubric of psychic trauma, the etiology of which was attributed to some nonspecific damage to the nervous system. In the years following the war, interest in the study of trauma faded once again and psychiatry quietly slipped into another period of amnesia (Herman, 1997; Van der Kolk et al., 1996).

The outbreak of new hostilities in Europe and the Pacific a few years later rekindled interest in the psychology of war that would become a watershed in the study of psychological trauma. Concerned by the economic costs of psychiatric casualties during World War I, the U.S. military undertook the use of psychiatric screening to identify and select out service personnel who were psychologically unfit to withstand the demands of combat (Marlowe, 2000). It became clear as the war continued, however, that while some men might be more likely than others to develop psychological symptoms in the face of battle, all men, no matter how brave, were vulnerable. With the widespread recognition that everybody had their breaking point, ideas about symptom formation on the battlefield shifted away from the biological or characterological inadequacies of the individual to the role of the environment in altering psychological and physiological behavior.

At the same time as these new ideas about psychological trauma were coalescing, the American psychiatrist Herbert Spiegel was in Tunisia evaluating the situation of the troops there. His mission was to develop preventative and treatment strategies that would minimize psychiatric casualties. Based on his observations, Spiegel (1944) concluded that the primary factor mediating a soldier's ability to cope with the trauma of combat was the support of his combat group. Where primary group affiliation was weak or absent, the potential for breakdown was very high. The risk was even higher when there was a lack of trust and/or communication between the combat group and its immediate leadership (Marlowe, 2000). In a later collaboration, Kardiner and Spiegel (1947) argued that the strongest protection against the overwhelming terror of combat was the degree of relatedness among the soldier, his immediate fighting unit, and their leader. This thinking paved the way for "front-line psychiatry" (Van der Kolk et al., 1996, p. 58), the fundamentals of which were proximity, immediacy, and expectancy. In an effort to limit the separation of troubled individuals from the protective effects of their fighting units, psychiatrists began to work out of mobile army hospitals situated near the fronts of battle. Treatment was brief and focused on resolution of immediate problems, with the expectation that the serviceman would return to their units as quickly as was feasible (Marlowe, 2000).

The recognition of the influence of the environment and interpersonal relationships in psychological illness and health heralded a paradigmatic shift in psychiatric doctrine. By the 1960s, psychoanalytic theory was in decline and new ideas from the social and behavioral sciences were being integrated into medicine. These influences energized an appreciation of the dynamic complexities of the environment–individual interaction and crystallized the concept of stress, as we understand it today. Working independently after the war, clinicians and researchers caring for and studying the experiences of Holocaust survivors (Krystal, 1968; Nathan, Eitinger, & Winnik, 1963), survivors of rape (Burgess & Holmstrom, 1974), battered children (Kempe & Kempe, 1978), and Vietnam veterans (Figley, 1978) developed discreet pockets of knowledge about the
effects of particular types of psychological trauma. It was not until the 1970s, however, that critical linkages would be made among these bodies of work. The impetus that drove the integration of these seemingly disparate works was the growing concern about the psychological problems experienced by returning Vietnam War veterans. Fueled by the human rights and antiwar sentiments of the previous decade, Vietnam veterans banded together to lobby the federal government for compensation. Sympathetic mental health professionals once again turned their attention to the effects of exposure to traumatic events. Together these forces influenced the third revision of the DSM (APA, 1980) in which both civilian (e.g., rape trauma syndrome, battered woman syndrome, abused child syndrome) and military trauma response syndromes were subsumed under the diagnosis of PTSD. It is important to note here that at the same time as the DSM-III PTSD working group was developing its ideas about the effects of trauma, unbeknownst to them another group was creating a diagnostic category for dissociative disorders (Van der Kolk, 1994). Because the two groups had no awareness of each other’s work (despite the centrality of trauma to both diagnoses) the initial formulations evolved in isolation of each other. Part II in this three-part series highlights how, as the study of trauma became more systematized and integrated, problems begin to emerge within the DSM taxonomy.

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References


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