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TOWARD AN UNDERSTANDING OF
POST-TRAUMATIC STRESS DISORDERS: AN
HISTORICAL AND CONTEMPORARY PERSPECTIVE

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ABSTRACT

This article traces the historical views that led to development of current scientific perspectives of the diagnostical concept post-traumatic stress disorder. Examples of the catastrophic precipitants of post-traumatic stress disorder, such as war, natural and man-made disasters, and rape are presented, and a description of the current clinical perspective is provided. Because post-traumatic stress disorder often involves all aspects of a person's life, the use of multimodal therapy soon after the trauma is experienced is recommended to prevent the symptoms from occurring.

INTRODUCTION

The purpose of this paper is to trace the historical views which led to the development and understanding of a diagnostical concept post-traumatic stress disorder (PTSD) and to highlight the current clinical picture along with the recent therapeutic approach called multimodal therapy. This account is intended to set the stage for more specialized issues related to PTSD which follow in this volume and to give the reader a broad understanding of the emergence of PTSD symptoms in a variety of situations.

There have been different views about the subject of PTSD which have changed with the passage of time. Until about two decades ago, the literature on the

subject lacked continuity and could only be characterized as anarchic (Kardiner, 1969). Every investigator had a point of view framed with circumstantial explanations. Various authors have also used different terms; for example, traumatic hysteria, traumatic neurosis, and situational crisis.

According to Trimble (1981), the debate over PTSD began in the 1860s with John Erichsen's lectures on certain obscure injuries of the nervous system: these injuries, according to Erichsen, were the result of shock to the body caused by railway accidents. Erichsen, a professor of surgery at University College Hospital in London, delivered lectures which were later incorporated into a book, On concussion of the spine: nervous shock and other obscure injuries of the nervous system in their clinical and medico-legal aspects (Erichsen, 1882) in which 53 case histories of patients who had received injuries of a wide variety were presented. Erichsen's work received wide attention in Europe as well as in the United States, and it later became an important reference in court cases dealing with compensation claims by victims of "shock." Thus, a legal point of view was established: that post-traumatic neurotic symptoms were based on somatic damage.

In 1889, Clevenger, an American physician, referred to the term "spinal concussion" as "Erichsen's disease" and considered it one form of the traumatic neuroses. The term "traumatic neurosis" was originally used by Oppenheim during the late nineteenth century in reference to the symptoms of concussion (Trimble, 1981). Oppenheim, a German physician, believed that the symptoms of traumatic neurosis were produced by molecular changes in the central nervous system (Trimble, 1981). Thus, PTSD came to be viewed as somatically based by most physicians between the 1860s and the early 1880s.

In 1885 Herbert Page, another British surgeon, published Injuries of the spine and spinal cord without apparent mechanical lesion, a refutation of the view held by Erichsen. Page dismissed the so-called "concussion of the spine" phenomenon and replaced it

with the explanation of "general nervous shock," thereby introducing the concept "functional disorders." This class of injuries was divided into two categories: organic, where injuries were clearly observable, and non-organic, where injuries were either slight or not observable. The non-organic causes were further divided into hysteria and malingering.

Hysteria achieved greater prominence with the work of Jean-Martin Charcot (1877), head of a neurological clinic for insane women in Paris and one of the most eminent neurologists of his time. Charcot investigated hysteria with the assumption that a common mechanism was responsible for the production of hysteria as well as other neurological disorders. During this same period hysteria continued to be ascribed to somatic bases; that is until Pierre Janet, Charcot's pupil and successor, challenged this knowledge. Janet rejected the assumption that hysteria was the result of physiological disorder, and, instead, considered it a symptom of mental disorder (Shultz, 1981). Thus, a dramatic conceptual shift occurred as the focus of the cause of hysteria changed from somatic in nature to psychic. Janet's work greatly influenced Sigmund Freud, the father of psycho-analysis, whose work later became the foundation for the grand theory of personality embraced during the early 1900s.

Freud broadened the meaning of hysteria and utilized the methods of treatment for hysteria which he had learned from Charcot. In 1886, Freud presented before the Viennese Medical Society a set of findings from which he equated post-traumatic neurosis with hysteria, a knowledge claim which became the point of dissent for Viennese physicians of that time (Ellenberger, 1970). In 1895, Freud published a book jointly with Josef Breuer entitled *Studies on hysteria*. The primary thesis of this work was that the symptoms of hysteria resulted from repressed memories of traumatic events. To support this notion Freud and Breuer documented the intrusion of "warded off" ideas, the compulsive repetition of behavior related to trauma, and recurrent attacks of trauma-related emotions (Horowitz and Solomon, 1975).

In time, Freud's original theory was modified; a changed emphasis began to be placed on ego function as opposed to a paradigm in which repressed impulses and the unconscious had been emphasized. Later theorists, such as Kamman (1951), viewed post-traumatic neurosis as a reaction to environmental factors involving personal failure in adaptation.

Kardiner's (1941) research focused on patients suffering with what was described as post-traumatic neurosis developed during war-time. Focusing on ego disturbances, Kardiner argued that symptoms related to the neurosis were not a result of conflict between two internal systems of the mind, but resulted from personal failure to adapt to a new or changed environment. Although many other studies have contributed to the clinical perspective of PTSD, its symptomology was first delineated by Kardiner (1969) as representing a mental disorder related to the traumatic neurosis of war.

In sum, PTSD has been the product of two historical schools of thought: the first perspective portrayed PTSD as resulting from somatic causes and the second view presented PTSD as a mental disorder. Then, around the turn of the century, a split between neurology and psychiatry occurred which led, in turn, to the recognition that functional disorders could develop without somatic causes. In more recent years PTSD has received considerable attention from social scientists and members of the helping professions. Numerous analysts have attempted to assess the nature, dynamics, and outcome of trauma-related disorders resulting from man-made catastrophes such as wars; natural disasters such as floods and accidents; and solitary catastrophes such as rape (e.g., Fairbank, et al., 1983; Kilpatrick, et al., 1979; and Wolfenstein, 1977). Examples of major precipitants of PTSD and a summary of the current clinical perspective are presented in the following sections.

MAJOR PRECIPITANTS OF PTSD

Man-made Catastrophes: Aftermath of War

According to Bootzin and Acocella (1984), most knowledge of PTSD has developed from studies involving survivors of war such as the two World Wars, the Korean and the Vietnam wars. Traumatic reactions to combat have been known by a succession of names such as "shell shock," "combat fatigue," "war neurosis," and "combat exhaustion." However, none of these terms represents a full and accurate description of PTSD because stress reactions to combat differ from one person to another (Bootzin and Acocella, 1984). Some soldiers suffer from fatigue and depression while others display intense anxiety escalating to panic attacks. The precipitating stimulus is usually the same, however,--a close escape from death and the trauma of seeing one's companions killed (Bootzin and Acocella, 1984).

In many instances soldiers do not manifest symptoms related to PTSD until they have returned to civilian life. Kardiner and Spiegel (1941) studied this problem in relation to both World Wars and concluded that war created a syndrome essentially no different from the traumatic neurosis of peace-time. Shell-shock, war neurosis, battle fatigue, and combat exhaustion, according to Kardiner and Spiegel, represent a manifestation of the same underlying cause--a common disorder resulting from war trauma.

Frederick Mutt, a British pathologist, coined the term "shell shock" during World War I (Coleman, et al., 1982). Mutt regarded such reactions as organic conditions produced by minute hemorrhages of the brain. It was found later, however, that only a very small percentage of combat cases showed physical injury. That is, most combatants suffered from physical fatigue and psychological shock. During World War II, the term "shell shock" was replaced by the term "war neurosis" and during the Korean and Vietnam wars, "combat fatigue" and "combat exhaustion" were introduced into the literature and the clinical vernacular.

Despite the varied terminology used to refer to PTSD, there was surprising uniformity in the general clinical picture which evolved during the war periods (Coleman, et al., 1982). The most common symptoms identified were dejection, weariness, hypersensitivity, sleep disturbances and tremors. In the majority of cases, soldiers who suffered from PTSD under combat conditions did not have history of prior maladjustment to military life, leading Kardiner (1969) to speculate that if it were not for the conditions prevailing during war, most soldiers would not develop PTSD. It has also been estimated that ten percent of American soldiers developed PTSD in World War II and, according to Bloch (1969), disabling combat exhaustion was the greatest single cause of manpower loss during that war. More recently Walker and Cavenar (1982) reported that of the 2.7 million Americans who served in the United States military during the Vietnam War, an estimated 20 to 25 percent continue to suffer from PTSD. In recognition of the enormity of the problem, the Veterans Administration began accepting PTSD in 1980, as defined by Diagnostic and statistical manual of mental disorder (DSM-III), as a compensable disability.

Man-made and Natural Disasters

Unfortunate as these are, disasters contribute a great deal to the understanding of PTSD. One of the earliest reports (Lindemann, 1944) evaluated the psychological symptoms experienced by survivors of the Boston Coconut Grove Night Club fire of November 29, 1942, in which a total of 493 people perished. Lindemann's work was later to become the cornerstone for the grief process theory and also served as the basis for the development of crisis theory.

Additional knowledge of PTSD developed in the aftermath of yet another tragedy. In 1972 the Buffalo Creek dam, constructed by the Buffalo Creek Mining Company, burst causing over one-hundred million gallons of mud to slide down the West Virginia hillside upon residents living in communities located below the dam. Within hours 125 people died and 4000 were left homeless (Erickson, 1976). Lifton and Olson (1976)

later categorized the PTSD symptoms manifested by the survivors into five categories. The first, death imprint and death anxiety, pertains to memories, visions, and recurrent nightmares of the death and massive destruction caused. The second category, death guilt, refers to survivor self-condemnation for having lived through the disaster while others perished. Psychic numbing, the third category, is characterized by a diminished feeling of self-worth among survivors involving apathy, depression, and a withdrawal from social intercourse. The fourth category, impaired human relationships, develops from the internal conflict between a need for love and succorance and the suspicion toward others who offer care or affection to disaster victims. The final category, the need to find significance, involves rationalizing the disaster to enable victims to resolve their inner conflicts.

Studies of other disasters, such as the Rapid city flood in 1972, the Three Mile Island Nuclear accident in 1979, the tornadoes in 1979 in two Texas communities--Vernon and Wichita Falls--, and the Kansas City Hyatt Regency disaster in 1981 further contributed to this knowledge base. According to Titchner, et al. (1976), such disasters tend to trigger an epidemic of PTSD, the frequency and intensity of which are determined by the nature of the impact, its duration, and the number of casualties.

The major feature of such disasters is that they affect a large number of people at the same time and create a state of emergency (Slaikeu, 1984). Such disasters are, of course, unexpected and cause the victims to experience severe psychological shock and to exhibit a response pattern consistent with "disaster syndrome." The disaster syndrome, according to Coleman et al. (1982), develops over three stages. During the initial shock stage, victims are stunned, dazed, and apathetic. They wander around aimlessly, cannot make sense of what is happening, and are unable to render aid to themselves or others. During the second stage, suggestability, victims become passive, suggestible, and appear willing to follow directives from almost anyone. In this stage victims also

express concern about others involved in the disaster. However, their behavior typically tends to be highly inefficient. In the final recovery stage, disaster victims begin to pull themselves together, think more clearly, and initiate constructive action. They are still tense, irritable, and hypersensitive to anything startling, however. Also, it is common that victims begin to discuss the disaster. Persons with acute episodes return to normal functioning after successfully passing through the three stages of disaster syndrome. However, individuals with chronic cases may continue experiencing symptoms of PTSD for several years after the disaster.

Solitary Catastrophes: Rape

The precipitant of PTSD need not be experienced en masse as, for example, in the case of flood, fire, or war. Rather, PTSD also evolves from solitary catastrophes such as rape (Rosenhan and Seligman, 1984). Recently there has developed an increased interest among mental health professionals and the general public over rape and related sexual abuse issues (King and Webb, 1981). Rape crisis was first described in detail by Burgess and Holmstrom (1974), who found that rape victims suffered significant physical and psychological trauma as a result of the rape. These analysts also noted that particular symptoms were exhibited by most victims regardless of their style of expression. Known as the "rape trauma syndrome," the reaction of most victims fall into three symptomatic categories: emotional responses, disturbances in functioning, and changes in life style (King and Webb, 1981).

Rape trauma syndrome strongly resembles the symptoms manifested in reaction to flood, combat, and concentration camps (Burgess and Holmstrom, 1979). Sleep disturbances, nightmares, genitourinary disturbances, and tension headaches are often evident. Similar to flood victims, rape trauma syndrome victims startle easily, and usually experience fear, depression, humiliation, anger, and self-blame. Sometimes phobias develop, and sexual fears are also common. In a recent study by Burgess and Holmstrom

(1979), it was found that four to six years after the rape, one-fourth of the victims still had not recovered from the trauma.

THE CLINICAL PERSPECTIVE

As abhorrent as war is, it has provided a "laboratory" in which the effects of severe environmental stressors on thousands of men can be evaluated. Similarly, disaster situations and personal catastrophes have not only added to the understanding of PTSDs for mental health professionals, but also provide insights for the general public as well. People are becoming increasingly aware of the potential impact of extreme stress and they have learned that anyone is vulnerable.

Post-traumatic stress disorder is characterized by anxiety. But PTSD differs from other anxiety disorders in that the source of stress is an external event of an overwhelmingly painful nature. A person's reaction, though it may resemble other anxiety disorders, seems to be justified (Bootzin and Acocella, 1984).

According to the DSM-III, PTSD is a psychological reaction to traumatic events that are generally beyond the range of common experiences such as bereavement, chronic illness, business loss, and/or marital conflict. The disorder may also evolve from physical damage such as head trauma, or body mutilation.

The symptoms characteristic of PTSD are reexperiencing the traumatic event, emotional anesthesia, and a variety of autonomic, dysphoric, or cognitive symptoms. The diagnostic criteria for PTSD, delineated in the DSM-III (1980:238) are as follows:

- A. Existence of a recognizable stressor that evokes significant symptoms of distress in most everyone.
- B. Re-experiencing of the trauma as evidenced by at least one of the following:

1. recurrent and intrusive recollections of the event
 2. recurrent dreams of the event
 3. sudden acting or feeling as if the traumatic event were recurring
- C. Numbing of responsiveness or reduced involvement with the external world beginning some time after the trauma, as shown by at least one of the following:
1. a markedly diminished interest in one or more significant activities
 2. a feeling of detachment or estrangement from others
 3. constricted affect
- D. At least two of the following symptoms that were not present before the trauma:
1. hyperalertness or exaggerated startle response,
 2. sleep disturbance,
 3. guilt about surviving when others have not, or about behavior required for survival,
 4. memory impairment or trouble concentrating,
 5. avoidance of activities that arouse recollection of the traumatic event, and
 6. intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

Other associated features include depression, anxiety, aggressive behavior, impulsive behavior, or organic mental disorders.

Impairment due to PTSD may be mild or it may affect nearly all aspects of life. The symptoms can either be experienced immediately or soon after the trauma, or they may emerge after a period of latency ranging from several months to several years after the traumatic event. When symptoms occur within six months of the trauma and/or the duration is less than six months, the disorder is considered acute. If the onset of symptoms develops more than six months after the event, it is delayed, and is considered to be chronic if the symptoms last longer than six months.

Furthermore, the disorder is usually longer lasting and more severe when a stressor is of human design.

Despite our increasing knowledge of the phenomenon, little is known about how to alleviate or prevent PTSD. Only minor improvements have been reported using drug therapy or psychotherapy in the treatment of trauma victims (Rosenhan and Seligman, 1984). Two confounding factors tend to cloud our understanding of improvement in PTSD cases. First, it is difficult to assess the health of the victim prior to the trauma since it is possible that individuals who suffer from the disorder may also have had poor adjustment prior to the trauma (Rosenhan and Seligman, 1984). Second, some victims remain ill for a long time because of the benefits or secondary gains involved (Trimble, 1981). According to Rosenhan and Selgiman (1984), careful longitudinal investigations of PTSD are required to provide the necessary evidence for determining who is more vulnerable to PTSD, the duration of the disorder, and to identify the most effective therapeutic techniques.

At the present time, the best solution to the problem appears to be preventive in nature. Therapists can attempt to reduce the effect of PTSD symptoms in trauma victims before they take hold (Rosenhan and Seligman, 1984). Sank (1979) reports that such a therapeutic attempt was successfully made by therapists from the Health Maintenance Organization, Washington, D.C., with the 154 men and women held hostage by the Hanfi Muslim at the B'Nai B'Rith National Headquarters during 1977. Therapy sessions, based on the multimodal behavior therapy introduced by Lazarus (1976), took place at the hostage site twice weekly for four weeks, and then follow-up sessions were held three months and one year later. The unique feature of this method appears to be its immediacy and the use of a broad-spectrum of intervention treatment techniques (Slaikeu, 1984). Since a follow-up of the victims was not carried out, the efficacy of this treatment method cannot be assessed (Rosenhan and Seligman, 1984). However, as a therapeutic approach it warrants further evaluation.

In conclusion, PTSD has appeared in many guises. Further, explanations and understanding of the disorder have been in relation to the disciplinary approach of the time and the zeitgeist. With the recognition of the psychological component of PTSD, current etiological knowledge is advanced enough that the disorder is now officially recognized by mental health professionals. Whereas the complex and varied nature of PTSD makes it difficult to delineate a specific preventive and therapeutic program, recognition and greater understanding of the disorder offers considerable hope for future therapeutic success.

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