A Short History of the Diagnosis of Posttraumatic Stress Disorder

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Prologue

On June 9th 1865, Charles Dickens was returning home from a visit to France. The final leg of his journey was a rail trip from the port city of Folkestone to London. Repairs were being performed on a bridge along the route, and two rails had been lifted off the track. The foreman overseeing the repairs consulted the wrong timetable that day, and wasn't expecting the train carrying Dickens until two hours after it was due. When the train arrived, it jumped off the track and the front cars plunged off of the bridge into the river below.[1]

Dickens' car hung off the track, but did not fall into the water. In a letter to his friend Thomas Mitton, Dickens described how he and two railway workers rescued the occupants of his car then got to "the hard work afterwards of getting out the dying and dead, which was most horrible.[2]" Dickens describes a few specific encounters during the rescue.

> Suddenly I came upon a staggering man covered in blood… with such a frightful cut across the skull that I couldn't bear to look at him. I poured some water over his face, and gave him some to drink, and gave him some brandy, and laid him down on the grass, and he said, 'I am gone', and died afterwards. Then I stumbled over a lady lying on her back against a pollard tree with the blood streaming over her face… I asked her if she could swallow a little brandy, and she just nodded, and I gave her some and left her for someone else. The next time I passed her, she was dead.[3]

By all reports, Dickens was calm throughout the incident. He even had the presence of mind to return to his car and rescue the manuscript of his novel *Our Mutual Friend* from his overcoat just before he was evacuated from the scene with the other survivors. The event, however, would affect him significantly over the upcoming years.

A year after the Staplehurst accident, Dickens wrote, since the accident "I have sudden vague rushes of terror, even when riding in a handsom [sic] cab, which are perfectly

[1] Ackroyd, pg. 953
[2] Dickens
[3] Dickens

unreasonable but quite insurmountable.[4]" His son observed, "we have often seen him, when travelling home from London, suddenly fall into a paroxysm of fear, tremble all over, clutch the arms of the railway carriage, large beads of perspiration standing on his face, and suffer agonies of terror.[5]" In addition to these symptoms of flashbacks and hyper-arousal, Dickens also exhibited avoidance behaviour – he would avoid trips that required using rail travel, and when this was not possible, sometimes he would suddenly get off of his train early and walk the rest of the way to his destination.[6] Dickens eventually withdrew from public events. These symptoms persisted until his death on the 5th anniversary of the Staplehurst accident.[7]

Introduction

Posttraumatic Stress Disorder (PTSD) is a condition in which a patient develops significant psychiatric symptoms after experiencing or witnessing some form of trauma.[8] Symptoms include flashbacks, avoidance-behaviour, hyper-arousal, memory impairment, and mood changes. The symptoms last longer than a month, and often do not present for months or years after the primary traumatic event. For a diagnosis to be made, the patient must experience significant distress or impairment due to the symptoms.

PTSD was first formally recognized by the medical community in 1980. Prior to this, no diagnosis existed that recognized the long-term or delayed effects of traumatic events. This is because the first psychiatric disease classification system was developed by the US military, and reflected that organization's bias towards focusing on the short-term and treatable effects of stress. Subsequent civilian classification systems built on the tradition established by this first system. It was not until victims of PTSD lobbied the medical community to recognize their condition that the diagnosis was formally integrated into medical classification systems.

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[4] Ackroyd, pg. 963
[5] Ackroyd, pg. 963
[6] Ackroyd, pg. 964
[7] Ackroyd, pg. 963
[8] DSM-5, code 309.81

War Neurosis

The First World War saw a great number of soldiers suffering from a new war neurosis. Patients presented with a wide spectrum of symptoms that could include; disorientation, loss of vision, anosmia, ageusia, and amnesia.[9] Military physicians noticed that patients often presented immediately following an artillery barrage, and the conclusion was made early on that these patients were suffering from neuro-trauma sustained secondary to the artillery blasts. Physicians called this novel form of war neurosis Shell Shock.[10]

The physical-trauma mechanism of Shell Shock was disproved relatively quickly, and by 1916 the British military were deploying psychiatrists in field hospitals to treat what was now recognized as a psychiatric-trauma. Frederick Dillon, a British psychiatrist, later explained his task in this way: "The problem was essentially a practical one – to evolve a method of dealing in a rapid and effective way with men whose adaptation to active war conditions had broken down, and to restore the adaptation.[11]" Dillon described his therapeutic approach; "no prolonged or elaborate analysis was necessary. In fact, for obvious reasons, such measures of treatment were contraindicated in the great majority of cases.[12]" The standard treatment regimen consisted of providing 3-4 days of bed rest, followed by hypnosis and methods to help the patient develop "adaptations" that would allow them to return to the front lines. While the vast majority of patients who presented with Shell Shock early in the war were pensioned and sent home to England, Dillon boasted that the new system of early treatment near the front resulted in 63.5% of patients returning to active duties.[13] US psychiatrists in the First World War were able to achieve a 75% rate of return with a similar treatment program.[14]

Most psychiatrists at the time believed that patients who developed a war neurosis were individuals who were predisposed to the condition due to weakness of character. When the Second World War broke out, US draft boards screened out over 1,000,000 draftees

[9] Myers, pg. 316
[10] Myers; Dillon
[11] Dillon, pg. 64
[12] Dillon, pg. 66
[13] Dillon, pg. 66
[14] Scott, pg. 296

on the basis that they were "psychologically unfit to fight.[15]" Believing that they had preempted the problem, the military made no plans to treat psychiatric patients at the front. However the rates of war neurosis, now called Combat Fatigue, were the same as they had been in the First World War. When psychiatric treatment was reintroduced at the front lines, the loss of troops to psychiatric illness again decreased significantly.

From the start of the Vietnam war, the US military provided medical personnel to treat psychiatric victims near the front lines. During 1965-1967 the rate of psychiatric casualties that required evacuation was less than 5 per 1000 troops[16]. Military leaders considered the problem of psychiatric trauma secondary to war to be under control.

Classification Systems

In 1946, the US military published the *Nomenclature of Psychiatric Disorders and Reactions*. Widely known as Medical 203, this document was the first published classification system of mental disorders. Medical 203 included the diagnosis of Combat Exhaustion. Combat Exhaustion was defined as "transient in character" and "justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress.[17]" The document states that when Combat Exhaustion was treated promptly, it would "clear rapidly." This diagnosis developed out of the military's experience of treating Combat Fatigue during the Second World War. It reflects that the military's goal at the time was to identify troops who were incapacitated due to acute stress, and treat them as efficiently as possible so that they could return to their active duties.

The only reference in Medical 203 to the long-term effects of experiencing stress is the diagnosis of Phobic Reaction. The document says that this can be a residual symptom after the other manifestations of Combat Exhaustion have subsided, but it can be controlled if the patient avoids the phobic object.[18] Nowhere in Medical 203 is there a reference to the long-term disabling effects of experiencing trauma. And this should

[15] Scott, pg. 296
[16] Scott, pg. 297
[17] Medical 203, pg. 289
[18] Medical 203, pg. 290

come as no surprise. The military does not benefit by highlighting the long-term disabilities that can arise from participating in warfare. Indeed, focusing on the long-term sequelae could hinder future troop enrollment, and negatively effect troop and public morale. This was especially true in 1946 – the year that Medical 203 was published, and the year that huge numbers of American troops were returning home from their service in the Second World War.

Soon after the publication of Medical 203, the American Psychiatric Association (APA) produced a civilian classification system called the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). DSM-1 was published in 1952 and was hugely influenced by Medical 203. Both documents had the same structure, and in some cases entire sections of the DSM were copied out of Medical 203 verbatim. One difference between the two documents is that the Medical 203 diagnosis of Combat Exhaustion was renamed Gross Stress Reaction[19] in the DSM. This broadened the diagnosis so that primary traumatic events could include situations outside of combat. Otherwise, both diagnoses emphasized that the condition was "transient in character" and would clear rapidly.[20]

In 1968, DSM-2 replaced DSM-1. The diagnosis of Gross Stress Reactions was replaced by Adjustment Reaction of Adult Life. [21] This new diagnosis was a subclassification of section 307 – Transient Stress Reactions. Nowhere in the DSM-1 or DSM-2 is there a diagnosis that recognizes the long-term disabling effects of experiencing a traumatic event.

Fighting for PTSD

Even though the US military believed that they were effectively dealing with the psychiatric toll on troops in the Vietnam War, soldiers and individual clinicians knew otherwise. Veterans were coming home with debilitating psychiatric symptoms. Clinicians working with veterans felt handicapped because none of the psychiatric diagnoses available to them accurately described the symptoms they were observing.

[19] DSM-1, code 54.0
[20] Medical 203, pg. 289; DSM-1, code 54.0
[21] DSM-1, code 54.0; DSM-2, code 307.3

Starting in the late 1960s, a small group of veterans and clinicians formed a working group to get a new diagnosis included in the upcoming DSM-3. The core of this group included Dr. Robert Lifton, Jack Smith, and Dr. Chaim Shatan.

Dr. Lifton was a psychiatrist in the US military during the Korean War. He had worked within the system that produced Medical 203, and he considered the historical collaboration between physicians and the military command to be an "unholy alliance.[22]" Jack Smith was a Vietnam veteran, and the director of a national organization[23] working to help vets reintegrate after the war. Dr. Chaim Shatan was a psychiatrist who presented a paper in 1972 on "post-Vietnam syndrome" which he described as "delayed massive trauma" that presented with guilt, rage, psychic numbing, alienation and the feeling of being scapegoated.

In 1975, the working group noticed similarities between the symptoms described in 'post-Vietnam syndrome', and 'survival syndrome' – a recently described collection of symptoms observed in concentration camp survivors.[24] Other authors were performing research on 'rape-trauma syndrome' and presenting similar results.[25] The working group compiled the available data on these newly described syndromes and incorporated it with case studies on over 700 Vietnam veterans prepared by Smith's organization. They then made their research public in a panel discussion at the APA's AGM in 1977. In this presentation, and in subsequent meetings, the working group proposed the inclusion of a new diagnosis in DSM-3: Catastrophic Stress Disorder. The APA's DSM-3 Task Force accepted the proposal almost verbatim, except that the name of CSD was changed to Posttraumatic Stress Disorder to make the diagnosis more inclusive of traumatic events associated with naturally occurring disasters.[26]

[22] Lifton in Scott, pg. 302
[23] National Veterans Resource Project
[24] Niederland, 1968
[25] Burgess and Holmstrom, 1974
[26] Scott, pg. 307

Conclusion

The cluster of symptoms described by PTSD was not a phenomenon that developed in the late twentieth century, when PTSD was first recognized. Records indicate that individuals have developed the symptoms of PTSD after experiencing trauma for centuries, if not much longer. The reason that early classification systems did not include a diagnosis for the long-term effects of experiencing trauma is because the US military, who wrote the first system, had an incentive to focus on the short term, and easily treatable, effects of stress from wartime experiences. It is due to the lobbying efforts of patients themselves, along with a few individual clinicians, that the diagnosis of PTSD is now formally recognized in the DSM.

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