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The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV

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The present study examined the evolution of the diagnostic criteria from the early writings of Sigmund Freud to the current DSM-IV. Freud's original model of neurosis, known as Seduction Theory, was a post-traumatic paradigm which placed emphasis on external stressor events. In 1897, due to a confluence of factors, he shifted his paradigm to stress intrapsychic fantasy as the` focus of analytic treatment for traumatic neurosis. Freud's thinking influenced both the DSM-I and 11 classification of stress response syndromes as transient reactive processes. However, it is evident from his lectures in 1917-1918 that he understood the interrelatedness of what today is the four diagnostic categories in the DSM-IV.

KEY WORDS: Freud; traumatic neurosis; PTSD; diagnostic criteria; DSM-I-IV.

INTRODUCTION

In the last quarter of this century, there has been a rapid proliferation of interest in traumatic stress syndromes, especially in post-traumatic stress disorder (MD) as a diagnostic category of the American Psychiatric Association (DSM-III-R, 1987). Viewed from a historical perspective, the emergence of widespread interest in PTSD by the medical and behavioral sciences as well as in legal arenas of litigation is quite understandable and, perhaps, expectable when examined by a retrospective look at some major events of the 20th Century: two World Wars; the atomic bombing of Hiroshima; scores of nationalistic and colonial wars; widespread civil violence; mass genocide; catastrophic disasters of human and natural origin; the

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growing awareness of domestic violence and childhood sexual abuse; technological disasters; famine; widespread diseases such as human immuno. deficiency virus (HIV) and many more forms of catastrophic stress. When it is considered that hundreds of millions of human lives have been adversely effected by such traumatic events, it only stands to reason that sooner or later scientific inquiry would accumulate enough momentum to begin examining the multifaceted aspects of what traumatization means and the potential long-term impact to human lives of such events. Today, there is a convergence of interest in PTSD and such seemingly odd bed-fellows as the neurosciences, experimental psychology, clinical psychiatry, and -sociology are probing new areas of traumatic impact and are discovering the complex psychobiological processes which control reaction patterns, symptom manifestation, and other aspects of coping and adaptation following a traumatic event (Wilson, 1989; Wilson and Raphael, 1993). While it is undoubtedly the case that human organisms have reacted to profound threat and danger from the time of the earliest person to the present day, the psychic residue of such exposure has most commonly been approached by examining the stress response, which itself has been conceptualized in many different ways (Peterson *et al.,* 1991; Wilson, 1989; Horowitz, 1986; Trimble, 1981, 1985). While it is beyond the scope of this paper to review the many theories of traumatic stress, it is worthwhile to examine seminal contributions that have had a profound influence on the evolution of the diagnostic criteria (DSM) for PTSD of the American Psychiatric Association (APA) as well as other medico-legal definitions throughout the world. In particular, the contributions of Sigmund Freud will be briefly reviewed because of their importance to European and American thinking about psychic trauma and placed into a historical and cultural perspective. It will be argued that Freud's conceptualization of traumatic neurosis dominated thinking in the medical-psychiatric profession from about 1895 to the end of the Vietnam War era in the United States (1962-1975). As will be shown later, Freud's conceptualization of traumatic neurosis was basically rewritten into the DSM-I (1952) diagnostic criteria for Gross Stress Reaction, the earliest DSM diagnostic category for what is 'today codified as PTSD in the DSM-III-R (1987). Then, from DSM-I to DSM-II (1968) changes began to unfold that, on the one hand are very puzzling (if not regressive) and, on the other hand, reflect the paucity of hard-headed thinking and empirical inquiry about the human consequences of victimization and traumatization. After the DSM-II, PTSD appeared in DSM-III and the stateof-the-art was changed in a direction of rapid knowledge accumulation and research proliferation in something akin to "light year" speed on a global level (Wilson, 1989; Wilson and Raphael, 1993).

FREUD'S PERSPECTIVE OF PSYCHOLOGICAL TRAUMA: 1895-1939

In 1895 Freud published with Josef Breuer *Studies in Hysteria* which launched his brilliant career up to the time of his death in 1939, at ti beginning of World War II. Between 1895 and 1897 Freud shifted emphasis in his thinking away from a PTSD paradigm of neurosis to one that cc tered around intrapsychic fantasy.

While a complete discussion of Freud's contribution to the understanding standing of psychic trauma is beyond the scope of this paper, there a several issues in his work of major significance to the understanding
how the diagnostic criteria (DSM of the American Psychiatric Associatio evolved in the United States and elsewhere.

To establish a broader historical framework, it should be noted that Freud's original view of neuroses was a post-traumatic paradigm knot within psychoanalytic circles as "Seduction Theory." In this early theoretic and clinical formulation (e.g., *Aetiology of Neuroses,* 1896) Freud stated that during childhood development there was a range of traumatic experiences or an emergency type of event that could be profoundly distressing to individual (Brett, 1993). As a result of the degree of threat experienced the ego and the subsequent anxiety experienced, the victim typically us repression as an ego-defense to remove from awareness unpleasant memories ries and emotions of the traumatic event. Once repression was employ various neurotic symptoms and behaviors would appear and potentially le the person into treatment. Moreover, Freud's early thinking about trauma also involved the concept that children were sexual beings from birth d ward and that the sexual instinct was one of the basic libidinal forces that could lead to intrapsychic conflict which could result in neurotic sympton neuroses or "the psychopathology" of everyday life. As many scholars ha noted (Jones, 1953, pp. 287-319), Freud's emphasis on sexuality as a cause of neurosis was not well received in conservative Vienna during his ea years as a physician and, amidst criticism and peer pressure, he began 1897 revising "Seduction Theory" to suggest that the memories of patient seeking treatment may only have been fantasies of such events which h their origin in libidinal drives and conflicted or deprived attachments parental figures (Masson, 1984). Freud's biographer, Ernest Jones (19_` noted this change in his theory of hysteria, the neuroses and their relati to trauma and emphasized that Freud wanted to shift emphasis away from the reality of a trauma history to a focus on "psychical" phenomena which he thought fantasy, imagery, and thoughts were more central analysis than actual memories of early childhood abuse. Thus, in 1897 his correspondence to his friend Wilhelm Fleiss, Freud revealed his aban-

donment of Seduction Theory to a conceptual model which emphasized the role of fantasy in intrapsychic processes. This view was later stated directly, as in this passage from *The Introductory Lectures on Psychoanalysis* (1917).

> It will be a long time before he (the patient) can take in our proposal that we should equate phantasy and reality and not bother to begin with whether the childhood experiences under examination are the one or the other. Yet, this is clearly the only correct attitude to adopt towards mental productions. They too possess a reality of a sort. It remains a fact that the patient has created these phantasies for himself, and this fact is of scarcely less importance for his neurosis than if he had really experienced what the phantasies contain. These phantasies possess psychical as contrasted with material reality, and we gradually learn to understand that in the world of neuroses it is psychical reality which is the decisive kind. (1966, p. 368)

Freud's shift of emphasis away from a post traumatic "Seduction Theory" to an instinct driven oedipal model with focus on intrapsychic mechanisms also had the consequence of disavowing, minimizing or recasting the role of external, event-based stressor experiences that negatively impacted on the process of psychosexual development (Masson, 1984). Further, while it is clear that Freud understood traumatic neurosis (see below), his shift away from a post-traumatic paradigm of neurosis to an oedipal model replete with "phantasies of a psychical vs. a material reality" naturally led to an examination of *pre-morbid* psychic functioning as a determinant of mental disturbances, especially anxiety states and neuroses. As will be evident in the explicit DSM-I (1952) criteria for Gross Stress Reaction (GSR), Freud's shift in paradigms also led to the formulation that traumatic impacts to the self-structure were *acute and transient in nature.* Thus, if there were *prolonged* reactions to trauma, they were not caused directly by the "material reality" of stressor events but by the pre-morbid traits and psychodynamics of the individual.

Sigmund Freud was no stranger to understanding trauma and it; symptom constellations. In various works he elaborated on the nature of traumatic neurosis and its mechanisms. For example, in *The Introductory Lectures on Psychoanalysis* published in May, 1917, Freud wrote as follows

> The closest analogy to this behavior of our neurotics is afforded by illnesses which are being produced with special frequency precisely at the present time by the war -what are described as traumatic neuroses. Similar cases, of course, appeared before the war as well, after railway collisions and other alarming accidents involving fatal risks. Traumatic neuroses are not in essence the same thing as the spontaneous neuroses which we are in the habit of investigating and treating by analysis; nor have we yet succeeded in bringing them into harmony with our views, and I hope I shall be able at some time to explain to you the reason for this limitation. But in one respect we may insist that there is a complete agreement between them. The traumatic neuroses give a clear indication that a fixation to the traumatic accident lives at their root. These patients regularly repeat the traumatic situation :., their dreams; *where hvsteriform* attacks occur that admit of an analysis, we find that the attack corresponds to a complete transplanting of the patient into the traumatic situation. It is as though these patients had not yet finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been dealt with; and we take this view quite seriously. (1966, pp. 274-275)

This passage is quite interesting from a historical perspective for several reasons when scrutinized by the DSM-III-R (1987) diagnostic criteria for PTSD. First, Freud recognizes that prior to the 1917 publication date of his book there were stressor events (e.g., WWI; railroad collisions; physical injury; fatal risk accidents, child abuse, etc.) that generated "illnesses" with "special frequency." He acknowledges that it was not uncommon for such traumatic events to produce a "traumatic neurosis." Second, he hints al the fact that traumatic neuroses are not the same phenomenon as spontaneous neuroses and yet fails to explain the difference. Third, he very clearly describes the core PTSD symptom clusters listed in the DSM-III-R 70 year; before the revision of the diagnostic category. For example, (a) *intrusive imagery;* ("patients regularly repeat the traumatic situation in their dreams"); (b) *physiological hyperactivity;* ("hysteriform attacks occur-the attack corresponds to a complete transplanting of the patient into the trau. matte situation); (c) *active re-living as if the event were re-occurring;* (-"it is as though these patients had not finished with the traumatic situation, a: though they were still faced by it as an immediate task which has not beer dealt with"). This last criteria implies that the traumatic event was not yet metabolized psychologically (Lindy, 1993). Further, it was not only active in the form of intrusive imagery associated with the trauma, but by attempt; to ward off its impact to the ego.

While it appears that Freud was attempting to build a parsimonious psychological theory of ,behavior in which instinctual forces gave rise to epiphenomenal psychic reality in various states of consciousness, it is aparent that he sought to understand different types of traumatic neurosis, especially those created by warfare. For example, on September 28th and 29th in 1918, at the proceedings of the fifth International Psycho-Analytica Congress held in Budapest, Hungary, he wrote of traumatic neuroses in ; way which illustrated his difficulty in explaining the different mechanism which underlie "ordinary neuroses" and "war neuroses." In war neuroses there is a conflict between the Superego and the Id such that the neurosis is a form of compromise to the horror of warfare, states of fear and aggression. He further elaborates on this change in ego state (i.e., peacetime ego versus war-affected ego) and notes that in war neuroses, the threat t the ego is external in the form of annihilation or physical injury. Nevertheless, he deduces that in either traumatic neurosis or war neurosis, repression is the central psychological defense against anxiety and libidinal gratification.

> In traumatic and war neuroses the human ego is defending itself from a danger which threatens it from without or which is embodied in a shape assumed by the ego itself. In the transference neuroses of peace the enemy from which the ego is defending itself is actually the libido, whose demands seem to it to be menacing. In both cases the ego is afraid of being damaged-in the latter case by the libido and in the former by external violence. It might, indeed, be said that in the case of the war neuroses, in contrast to the pure traumatic neuroses and in approximation to the transference neuroses, what is feared is nevertheless an internal enemy. The theoretical difficulties standing in the way of a unifying hypothesis of this kind do not seem insuperable: after all, we have a perfect right to describe repression, which lies at the basis of every neurosis, as a reaction to a trauma-as an elementary traumatic neurosis.'

Moreover, in a continuing analysis of the etiology of traumatic neuroses, Freud rejects that they are due to an organic cause (i.e., shell shock or physical concussion to brain tissue) but are functional in nature.

> Although the war neuroses manifested themselves for the most part as motor disturbances--tremors and paralyses-and although it was plausible to suppose that such a gross impact as that produced by the concussion due to the explosion of a shell nearby or to being buried by a fall of earth would lead to gross mechanical effects, observations were nevertheless made which left no doubt as to the psychical nature of the causation of these so-called war neuroses. How could this be disputed when the symptoms appeared behind the front as well, far from the horrors of war, or immediately after a return from leave? The physicians were therefore led to regard war neurotics in a similar light to the nervous subjects of peace-time. (Standard Edition, Volume XVII, 1955, p. 206-211. J. Strachy, ed.)

This passage foreshadows his latter (1928) thinking that trauma produces physical and psychological disequilibrium within the ego; nevertheless he sustains the view that it is the "psychical nature of the causation" that is decisive in the determination of symptomatology.

BEYOND THE PLEASURE PRINCIPLE: TRAUMA AS DISEQUILIBRIUM

In 1928 Freud published one of his last books, Beyond the Pleasure Principle. Once again he addressed the issue of traumatic neuroses and utilized the metaphor of the "protective shield of the ego" for defensive mechanisms (Brett and Ostroff, 1985). In this work, he considered traumatic events as external stressors that were strong enough to break through the "protective shield" and inflict injury or harm to the person.

> We describe as "traumatic" any excitations from outside which are powerful enough to break through the protective shield. It seems to me that the concept of trauma necessarily implies a connection of this kind with a breach in an otherwise efficacious barrier against stimuli. Such an event as an external trauma is bound to provoke a disturbance on a large scale in the functioning of the organism's energy and to set in motion every possible defensive measure. At the same time the pleasure principle is for the moment put out of action. There is no longer any possibility of preventing the mental apparatus from being flooded with large amounts of stimulus, and another problem arises instead-the problem of mastering the amounts of stimulus which broke in and of binding them, in a psychical sense, so that they can then be disposed of. (1959, pp. 56-57)

In this later treatise one can now see that Freud further elaborated the concept of trauma as involving: (1) an external stressor event which overwhelms normal ego functioning; (2) a change in the steady state of the organism (i.e., disequilibrium); (3) a reduction of ego-defensive and coping capacity and (4) the problem of "mastery," in that other stressors can take on traumatic proportion. Thus, both the traumatic stressors and secondary ones can overwhelm the now depleted ego-defenses, thereby setting-up the possibility of long-term post-traumatic stress disorder and other co-morbid conditions.

While it may be surprising to some that Freud seemed to grasp the essence of post traumatic stress disorder in the early part of the 20th Century, what followed his death in terms of establishing diagnostic categories to aid victims of trauma both reflects his persona(contributions to the field and then a kind of intellectual vacuum in which the collective clinical wisdom about psychic traumatization seems to have gone "underground" and evaporated by the time of DSM-II *(1968)*. What makes this so peculiar is that by *1968* the cumulative historical events involving war, civil violence, nuclear warfare, etc. produced more trauma, killing, mass destruction and death in a delimited time frame than at any prior time in recorded history. Nevertheless, Freud's contribution to understanding PTSD-like states was in recognizing the power of trauma to change ego states and adaptive behavior. The greatest impact of his work, however, lay in the shift of conceptual paradigms from that of reality based, stressor event determinants of PTSD to a focus on fantasy and what he termed the psychical reality of memory. The implications of this conceptual shift in paradigm were enormous because it made pre-morbid determinants a primary consideration to the exclusion of the nature, magnitude and social-historical context in which traumatization occurred.

FROM DSM-I TO DSM-IV: A **RETROSPECTIVE LOOK AT THE PTSD DIAGNOSTIC CRITERIA**

DSM-I (1952)

Sigmund Freud died in *1939* after a protracted struggle with cancer at the advent of WW-II. In 1952, 13 years after his death, the American Psychiatric Association published its first diagnostic and statistical manual

which contained a diagnostic category known as "Transient Situational Personality Disorders" which included the category (000-x81) Gross Stress Reaction. Table I presents the reproduction of the DSM-I for this category which will be reviewed as it bears on the current diagnosis of PTSD.

Table I. DSM-I-1952 Mental Disorder

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

THIS GENERAL CLASSIFICATION SHOULD BE RESTRICTED TO REACTIONS WHICH ARE MORE OR LESS TRANSIENT IN CHARACTER AND WHICH APPEAR TO BE AN ACUTE SYMPTOM RESPONSE TO A SITUATION WITHOUT APPARENT UNDERLYING PERSONALITY DISTURBANCE.

THE SYMPTOMS ARE THE IMMEDIATE MEANS USED BY THE INDIVIDUAL IN HIS STRUGGLE TO ADJUST TO AN OVERWHELMING SITUATION. IN THE PRESENCE OF GOOD ADAPTIVE CAPACITY, RECESSION OF SYMPTOMS GENERALLY OCCURS WHEN THE SITUATIONAL STRESS DIMINISHES. PERSISTENT FAILURE TO RESOLVE WILL INDICATE A MORE SEVERE UNDERLYING DISTURBANCE AND WILL BE CLASSFIED ELSEWHERE.

000-x80 TRANSIENT SITUATIONAL PERSONALITY DISTURBANCE

TRANSIENT SITUATIONAL DISORDERS WHICH CANNOT BE GIVEN A MORE DEFINITE DIAGNOSIS IN THE GROUP, BECAUSE OF THEIR FLUIDITY, OR BECAUSE OF THE LIMITATION OF TIME PERMITTED FOR THEIR STUDY, MAY BE INCLUDED IN THIS GENERAL CATEGORY. THIS CATEGORY IS DESIGNED ALSO FOR THE USE OF RECORD LIBRARIANS AND STATISTICIANS DEALING WITH INCOMPLETE DIAGNOSES.

000-x81 GROSS STRESS REACTION

UNDER CONDITIONS OF GREAT OR UNUSUAL STRESS, A NORMAL PERSONALITY MAY UTILIZE ESTABLISHED PATTERNS OF REACTION TO DEAL WITH OVERWHELMING FEAR. THE PATTERNS OF SUCH REACTION DIFFER FROM THOSE OF NEUROSIS OR PSYCHOSIS CHIEFLY WITH RESPECT TO CLINICAL HISTORY, REVERSIBILITY OF REACTION, AND IT TRANSIENT CHARACTER. WHEN PROMPTLY AND ADEQUATELY TREAT THE CONDITION MAY CLEAR RAPIDLY. IT IS ALSO POSSIBLE THAT THE CONDITION MAY PROGRESS TO ONE OF THE NEUROTIC REACTIONS. IF THE REACTION PERSISTS, THIS TERM IS TO BE REGARDED AS A TEMPORARY DIAGNOSIS TO BE USED ONLY UNTIL A MORE DEFINITIVE DIAGNOSIS IS ESTABLISHED.

THIS DIAGNOSIS IS JUSTIFIED ONLY IN SITUATIONS IN WHICH THE INDIVIDUAL HAS BEEN EXPOSED TO SEVERE PHYSICAL DEMANDS OR EXTREME EMOTIONAL STRESS, SUCH AS IN COMBAT OR IN CIVILIAN CATASTROPHE (FIRE, EARTHQUAKE, EXPLOSION, ETC.). IN MANY INSTANCES THIS DIAGNOSIS APPLIES TO PREVIOUSLY MORE OR LESS "NORMAL" PERSONS WHO HAVE EXPERIENCED INTOLERABLE STRESS.

THE PARTICULAR STRESS INVOLVED WILL BE SPECIFIED AS (1) COMBAT OR (2) CIVILIAN CATASTROPHE.

DSM-I: GROSS STRESS REACTION

In the DSM-I the current diagnostic category of PTSD was formerly classified as Gross Stress Reaction (GSR). The description of GSR clearly reflects the influence of Freud's thinking about traumatic neurosis. As Table I indicates, there are several criteria implied by the narrative description. First, the placement of GSR into a category of transient situational personality disorders reflects the view that such conditions are expected to be acute reactions to "unusual stress" that resolve quickly. Second, if there are prolonged or persistent reactions an alternative diagnosis was to be considered by the clinician and implied the possibility of a pre-morbid condition. In DSM-I these alternatives included psychosis, neurosis (e.g., anxiety neurosis) or character disorders. Third, the criteria also notes that "when promptly treated, the condition may clear rapidly." This statement apparently reflected an assumptive belief that rapid intervention facilitates recovery from the impact of the stressful event, no matter how great was the degree of victimization.

In an interesting way, the DSM-I (1952) category of GSR had features which in many ways parallel the later DSM-111 (1980) criteria for PTSD such as the recognition that in "conditions of great or unusual stress." a normal person may manifest stress-related behaviors in response to "intolerable stress." Hence, a recognizable stressor could generate reactions and symptoms but only for the duration of the stressful event since it was presumed that "recession of symptoms generally occurs when the situational stress diminishes." It is here that we see the Freudian influence that a traumatic neurosis is caused by a "penetration of the protective shield of the ego" due to an excess influx of excitation in the mental apparatus within a short period of time. Thus, while a traumatic neurosis (i.e., GSR) may be produced, it was presumed to diminish once the event terminated. Persistence of traumatic reactions could only be due to underlying psychopathology which became more apparent because the ego now lacked the capacity to defend against pre-morbid and repressed infantile conflicts. Stated more basically, this view of GSR implies that trauma may aggravate repressed, latent or pre-existing intrapsychic conflicts but that the persistence of reactions is not primarily caused by the traumatic event. Thus, while the stress might be great, it also may weaken ego-defenses such that other emotional problems become manifest as well.

DSM-11: ADJUSTMENT REACTION OF ADULT LIFE

Table II summarizes the diagnostic criteria for PTSD as found in the DSM-II (1968). As can be seen, the second edition of the psychiatric manual

re-classified GSR into category (DSM 307.3) "Adjustment reaction of adult life," and provided three short (and inadequate) illustrations. How. ever, the asterisks by the diagnostic category name (see table illustration) told the user of the manual to look in the appendices for additional examples of stressful life-events and listed such things as motor vehicle traffic accidents, railway accidents, water transport accidents, air transport accidents and more, ad nauseam, in a highly compartmentalized and obsessive-compulsive style. However, what is interesting about these examples is that the DSM-11 committee clearly recognized that there were stressor events that contained a possible physical threat of injury or death, or were psychologically associated with states of fear and anxiety. However, given such extensive codification of external stressor events, one must question why the committee did not go further in determining how these types of events relate specifically to adjustment reactions.

It is puzzling that in the 16 year interval between the publication of DSM-I and DSM-II, there were more world wide traumatic events that were the focus of both national and international attention: the Korean and Vietnam Wars; Colonial Wars and revolutions; the assassination of John F. Kennedy; civil violence in Northern Ireland; wars in the Middle East; major natural disasters in many parts of the world and recognition of the prevalence of childhood sexual abuse. These events and those that preceded in the period from 1900-1952 were being investigated, researched and published in medical and scientific journals (e.g., A. Kardiner's book on Traumatic *Neurosis of* War (1941, 1959) and Lifton's landmark 1967 book on Hiroshima-Death in Life). And yet the DSM-II equivalent of PTSD contained a mere three examp les of "adjustment reaction to adult life": (1) an unwanted pregnancy accompanied by depression and hostility; (2) a frightened soldier in combat; and (3) a prisoner facing execution in a death penalty case.

Table II. DSM-11 -1968

307.3' ADJUSTMENT REACTION OF ADULT LIFE`

EXAMPLE: RESENTMENT WITH DEPRESSIVE TONE ASSOCIATED WITH AN UNWANTED PREGNANCY AND MANIFESTED BY HOSTILE COMPLAINTS AND SUICIDAL GESTURES.

EXAMPLE: FEAR ASSOCIATED WITH MILITARY COMBAT AND MANIFESTED BY TREMBLING, RUNNING AND HIDING.

EXAMPLE: A GANSER SYNDROME ASSOCIATED WITH DEATH SENTENCE AND MANIFESTED BY INCORRECT BUT APPROXIMATE ANSWERS TO QUESTIONS.

The simplicity and inadequacy of these examples gives pause to in quire as to why there was not a more adequate and complete delineation of the various types of trauma; their common effects on psychological functioning and the known clinical features associated with such stressful life experiences. At one level, it is apparent that the committee who drew up the revised DSM-11 category implicitly understood that certain types e events were more likely than others to be associated with difficulties ii adjustment. And yet it was apparent, as suggested earlier, that Freud in adjustment understood in 1917, 70 years before DSM-III-R, the core system clusters c PTSD that are currently accepted by most professionals who work wit; traumatized clients. While it is beyond the purpose of this paper, a retrospective analysis and reconstruction of how the DSM-11 (307.3) diagnostic criteria came into being in the form it did in light of the extensive extant literature at that time on various trauma populations would be interesting and important to understand.

DSM-III: POST-TRAUMATIC STRESS DISORDER (1980)

Twelve years after DSM-I1, PTSD emerged as a separate diagnostic entity and was placed among the anxiety disorders, presumably because anxiety, emotional distress and physical disequilibrium were among the pr: mary affective reactions associated with traumatization. Further, to receive a diagnosis of PTSD the individual had to manifest at least four symptom (e.g., intrusive recollections) from three clusters of symptoms (12 total which included forms of reexp eriencing the trauma; numbing and detachment responses and changes in personality that were not present *before the* trauma (e.g., sleep disturbance, survival guilt). As with the other mental disorders listed in DSM-III, the PTSD diagnostic considerations were constructed as an algorithm for differential diagnosis and were not meant t be exhaustive of all possible symptoms that a survivor might possess. More over, a careful look at the PTSD diagnostic criteria reflects what Freud (1917) had earlier observed: namely that the impact of trauma is systemic and influences emotional expressiveness; -cognitive processes; motivation and goal striving; interpersonal and object relations; physiological functioning and ego-states.

The DSM-III also made a number of advances over the previous DSM- I and DSM-11 in that the narrative description of the disorder contained in the manual explained PTSD syndrome dynamics and made other observations that were not previously elucidated, such as the role of dissociative processes (e.g., "flashbacks," forms of re-enactment) in post-traumatic a tempts at coping and processing the trauma. Moreover, the prime criterion

of diagnostic consideration was "the existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone."

Clearly, this statement is of etiological significance since it implies that the *magnitude of the stressor* is sufficient to generate traumatic reactions in almost everyone which, in turn, might develop into a pathological state. In this regard it is possible to see how researchers such as Lifton (1988) indicated that, to a large extent, PTSD can be thought of as the normal human reaction to abnormally stressful life-events. In this perspective the reactions and symptoms of the syndrome are expectable, predictable, and normative. However, the psychopathology of traumatic reactions is discerned when the presence of the symptoms persists and exerts an adverse effect on adaptive functioning. *Thus, there is not only a continuum of symptom severity but also a continuum of pathological impact on psychosocial functioning.* Further, the concept of a continuum of symptom severity and pathological impact then implies that there are variables and processes that moderate both manifestations. Most typically, researchers have postulated that personal variables (e.g., personality traits) or environmental factors (e.g., level of perceived social support) influence the specific patterns of PTSD expression (Wilson, 1989).

While it is possible to engage in an extended discussion of the historical importance of PTSD as a separate diagnostic entity in the DSM-III (1980), a few points should be mentioned at this juncture. First, the nomenclature of the disorder was important. The words "post-traumatic" mean "after injury" and indicate that there is a change in state of well-being which is associated with various reaction patterns and symptom formation. Second, although PTSD was initially a controversial diagnostic category in some medical-legal circles, the net effect to date has been to stimulate more research programs, promote clarification in terms of differential diagnosis and the understanding co-morbid conditions (Davidson and Foa, 1993; Wilson and Raphael, 1993). Third, the existence of PTSD also helped to validate and legitimate the suffering of those victimized by stressful life-events. Similarly, the availability of PTSD as a diagnostic category for consideration also helped to avoid misdiagnosis and by implication, possible mistreatment. Fourth, the existence of PTSD as an officially recognized mental disorder enabled it to be used in legal considerations for such things as securing disability payments, pensions, compensation for injury or as a form of legal defense in criminal litigation. Fifth, the rapid proliferation of clinical and research studies with different populations of trauma victims (e.g., childhood abuse, rape victims, war veterans, disaster survivors, etc.) led to new questions and refinements in understanding the complexity of stress response syndromes. Today, this process is in full momentum and such new publications as *The International Handbook of Traumatic Stress Syndromes* (Wilson and Raphael, 1993) reflect the emerging international collaboration in studies of disaster, trauma and victimization. Finally, the power of the momentum generated throughout the 1980s and continuing toward the dawn of the 21st Century have brought ford new revisions in the criteria that were evident in the DSM-III-R and the forthcoming DSM-IV (Davidson and Foa, 1993).

DSM-111-R (1987): POST-TRAUMATIC STRESS DISORDER, REVISED

In 1987 the committee of the APA decided to revise the diagnostic criteria for PTSD. (The author was a member of the DSM-111-R Committee on PTSD.) These revisions reflected a knowledge from research and clinical work with victims of trauma. The total number of diagnostic symptoms were expanded to 17 and to receive a clinical diagnosis, the client had to manifest 6 symptoms from the three major clusters: forms of reexperiencing the traumatic event (DSM-III-R-B criteria); avoidance and numbing reactions associated with the traumatic event that were *not present before it* (DSM-III-R-C criteria) and; symptoms of increased physiological arousal that *were not present before the trauma* (DSM-III-R-D criteria). Additionally the criteria also stated that the duration of the disturbance (i.e., symptom: or reactions) had to be at least one month. If the on-set and off-set of the reactions was less than a month, the condition was to be regarded as a nor mal pattern of stress response that was not pathological in nature.

The changes made in the DSM-111-R diagnostic criteria were more than simply adding additional symptoms to a list. The revision also at tempted to clarify language, meaning and specificity of reactions to trauma I will discuss these in the next session.

I. Definition of Trauma

In DSM-III (1980) the "A" criterion for PTSD was a generic definition of stressors associated with post-trauma symptom development. As investigators evaluated impacts of different stressful events it became less clear what was meant by the 1980 (A-criterion) phrase, "a recognizably stressor that would evoke significant symptoms of distress in almost every one." The problem here, as noted earlier, rests with the fact that there is a stress-threshold continuum and a recognizable stressor to one person ma; not be so to another. Thus, the DSM-111-R "A" criterion attempted to clarify that the stressors associated with the onset of PTSD were external events outside the usual range of daily hassles that would be "markedly distressing

to almost everyone." This criterion is then followed by examples of: (1) physical life threat; (2) psychological threat to well-being; (3) physical or psychological threat to the well-being of significant others; (4) the witnessing of horrific trauma or (5) involvement in a disaster of natural or human induced origin. In essence, the revised (1987) "A" criterion was to indicate that the stressors that are associated with the onset of PTSD are generally at the extreme end of the stress continuum and that the more severe and life-threatening is the event, the higher is the probability that it will produce traumatic consequences such as PTSD or other forms of psychopathology.

II. Reenactment and Reliving Trauma

The 1987 revision also sought to clarify the various ways that traumatic events can be reexperienced. First, the explicit "B" criteria noted that the traumatic event is persistently reexperienced. Second, that reexperiencing trauma as a part of PTSD is different than a memory of trauma. The visual imagery and emotional distress in PTSD is intrusive, unbidden (Horowitz, 1986), involuntary and unexpected. Third, the different ways individuals relive trauma were also more finely detailed in the 1987 revision and included: (a) nightmares of the traumatic event; (b) daytime intrusive imagery and affect of the trauma (e.g., emotional "flooding"); (c) sudden acting or feeling that the traumatic event might reoccur; (d) dissociative states in which the traumatic event is reexperienced or acted-out in behavior (i.e., symbolically or as repetition of the earlier event); (e) hallucinations that are trauma-based; (f) increased distress upon exposure to events or stimuli that either symbolize or resemble the original trauma; (g) anniversary reactions during the course of the year and (h) repetitive play activities in children that are an expression of preoccupation with the traumatic event. Thus, the revised "B" criteria in DSM-III-R indicated 8 possible forms of reexperiencing a traumatic event, five more than the 1980 revision.

III. Avoidance, Numbing, Detachment, Emotional Constriction, and Amnesia

It should come as no surprise that if there were discovered more ways in which people relive a traumatic event, that there would be a corresponding number of ways to avoid its impact or to numb or diminish painful emotions associated with memories of the trauma. The 1987 revision described seven categories of avoidance symptoms and included the following: (i) avoidance of thoughts, feelings, situations and activities associated with the trauma or likely to stimulate recollections; (ii) psychogenic amnesia; (iii) regression or developmental arrestation; (iv) loss of interest or meaning in previously enjoyed activities; (v) detachment, estrangement and isolation from others; (vi) loss of emotional expressiveness and capacity for love, sexuality, intimacy, and friendship; (vii) changed beliefs about personal well-being in the future.

In summary, the avoidance and numbing criteria can be thought of, in an overly simplistic sense, as characterizing self-other object relations. There is intrapersonal constriction, numbing, denial and splitting. Similarly, there is interpersonal detachment, distancing, withdrawal, and avoidance, In terms of ego function there may be cognitive-constriction, loss of memory, meaning, purpose and qualities of the self structure.

IV. Physiological Hyperarousal: Psychobiological Manifestations

Among the more significant major changes in the DSM-111-R was the re-orientation of the "D" diagnostic category. In the 1980 version, the symptom cluster was concerned with changes in personality and behavior that were not present before the traumatic event. In the 1987 revision, the category directly concerned states of increased *physiological arousal,* under scoring recent advances in the psychobiology of PTSD (Friedman, 1993 Wilson, 1989). Further, whereas there still remained 6 symptoms within the "D" category, survivor guilt, memory impairment and hyperalertness had been deleted from the DSM-III edition and replaced with irritability or outbursts of anger, hypervigilance and physiologic reactivity upon expo sure to stimuli that activated memories of the traumatic event. Thus, the revised (D) category for "persistent systems of increased arousal" was added to the other two categories to form an interrelated symptom triad (1) intrusive states of reexperiencing the traumatic event; (2) avoidance and numbing reactions and (3) disequilibrium states as expressions o changes in nervous system activity.

DSM-IV AND BEYOND

At this writing the DSM IV diagnostic criteria for PTSD are being finalized (Davidson and Foa, 1993). Fundamentally, they appear to contain minor revisions in the language for defining the criteria established in the DSM-III-R. But with the rate at which new discoveries are being made in the study of traumatic stress syndromes, there are considerations for the future that must be addressed more thoughtfully and systematically. Let consider a few of them.

Is PTSD an environmentally caused disorder? If the answer is au unequivocal yes, should PTSD then be classified separately in the diagnostic manual? Pynoos and Nader (1993) have suggested separate diagnostic criteria for childhood MD. Similarly, Terr (1991) has identified Type I and Type II childhood stressor events with differential consequences for PTSD manifestation and character changes. Ochberg (1988,1993) has also suggested that victims of torture, terrorism and degradation may experience a victimization disorder which overlaps with PTSD but has different psychic consequences as well. Braun (1993) has also suggested that PTSD and dissociative disorders may have a common psychological pathway to symptom formation.

There are several other phenomena associated with trauma and disaster that require much more research and evaluation. For example, Laibow and Laue (1993), Wilson (1990), and others (Vyner, 1987) have described anomalous traumatic experiences, such as exposure to invisible toxic contaminants, that have unique properties such as difficulties discerning the nature of the stressors or their long-term consequences to physical and emotional well-being. In technological disasters, those affected often manifest states of chronic uncertainty, anxiety, obsessive behavior, hypervigilance and somatoform processes (Vyner, 1987). Are such reactions a form of PTSD? Or are there sub-clinical levels of PTSD as well? Moreover, how do we understand the acute or persistent effects of dysfunctional families, civil chaos and violence, unstable cultural systems or similar events that impact adversely on the well-being of victims? Do the persistent effects of unstable, chaotic, threatening and inconsistent environments (e.g., civil violence, gang warfare, etc.) eventually begin to function in a manner similar to a discrete, major catastrophic life-event? If so, are these patterns of adaptation a subtype of PTSD?

These and other questions await future research and clinical insights. What seems clear at this point in the continuing evolution of MD diagnostic criteria is that the inquiry probed by Freud, expanded by others in the wake of unprecedented historical 20th century events of cataclysmic proportion, and being pursued vigorously by scholars world wide on the dawn of the 21st Century, is nothing less than a willingness to address the psychic impact of traumatic injury and thereby seek solutions to healing and the restoration of humaneness.

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