

CHAPTER 3



Historical Roots of the PTSD Construct

HOW PTSD BECAME A DIAGNOSIS AND LAUNCHED THE TRAUMATIC STRESS FIELD

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Those who cannot remember the past are condemned to repeat it.

—GEORGE SANTAYANA

History doesn't repeat itself, but it often rhymes.

—MARK TWAIN

The inclusion of the posttraumatic stress disorder (PTSD) diagnosis in DSM-III in 1980 was a key moment in the history of the traumatic stress field (American Psychiatric Association [APA], 1980). This diagnosis catalyzed the growth of the traumatic stress field by providing a common metric with which to measure the impact of exposure to disparate potentially traumatic events (PTEs), thereby encouraging clinicians, researchers, and activists to recognize commonalities across different types of PTEs. Having the PTSD diagnosis clearly facilitated better assessment, treatment, and research. Having this diagnosis stating that a specific set of symptoms can be caused or aggravated by exposure to PTEs had a major impact on public policy debates in many areas, including whether compensation for disaster survivors, accident victims, crime victims, and veterans is appropriate, as well as on funding priorities for traumatic stress research and treatment services. As we describe in this chapter, the PTSD construct as operationalized in DSM-III had many precursors, none of which were as comprehensive or universal as PTSD.

Given the importance of PTSD in DSM-III to the traumatic stress field, this chapter examines how PTSD achieved diagnostic status at this particular time, thereby obtaining a degree of public, professional, and public policy acceptance that was never possible before. There are important lessons to be learned about how this came to be, and it is critical that we learn them for two reasons. First, as Santayana's quote implies, we must learn from the past to avoid making the same mistakes (i.e., reinventing the flat

tire) but also to learn from and replicate what worked well. Second, as Twain's quote indicates, many of the historical challenges for our field have, and will continue to, repeat themselves in slightly different forms, and we must be ready to recognize and address them.

This chapter does not provide a detailed account of all the important historical contributions of clinicians and researchers that culminated in PTSD in DSM-III. That appears in two excellent chapters in the previous edition of this book (Monson, Friedman, & La Bash, 2007; Weisaeth, 2007). Nor do we describe the evolution of the PTSD construct since 1980 or the tremendous progress made by the traumatic stress field since then because these are described elsewhere in this volume. This chapter does provide an overview of people and events that contributed to developing the societal acceptance of the impacts of psychological trauma and the PTSD construct. However, our primary aim is to examine the barriers that hindered the professional acceptance of the importance of traumatic stress as a fundamental aspect of psychopathology before 1980. We also explore the events and social forces in the 15 years prior to DSM-III in 1980 that enabled the PTSD construct to win acceptance and achieve diagnostic status.

In our view, acceptance of precursors of what we now call PTSD and PTSD itself faced three major barriers. First, professional interest in traumatic stress has never been sustained over time. Interest in and prioritization of traumatic stress have been cyclical in nature, characterized by periods of intense interest followed by dramatic forgetting of the lessons of the past (Kardiner & Spiegel, 1947). Our past is littered with false starts and mistakes as well as successes, but lack of continuity of interest, work in the area, and ability to learn from both successes and failures resulted in much re-inventing of both the wheel and the flat tire.

Second, supporters of the many precursors of the PTSD construct often found themselves in the midst of professional and public policy debates with high-stakes consequences, which precluded making policy decisions solely on the basis of facts or logic. The hypothesis that exposure to PTEs can cause substantial harm is a key premise of both the PTSD construct and its precursors. This clearly falls on the environmental side of the nature versus nurture debate that goes back to the Greek philosophers. If exposure to PTEs causes harm, this creates challenges for those making policies regarding treatment of injured members of the armed forces, compensation for victims of war, crime, or torture, and the question of whether the harm is sufficient to require special consideration under the law (Kilpatrick, 2005). As will be described, there are generally strong institutional forces that discount the harm produced by exposure to PTEs or that attribute any harm to nature rather than nurture for political or financial reasons. These vested interests made it more difficult for PTSD and its precursors to gain recognition.

Third, a striking lesson of history is that many clinicians have failed to recognize the trauma experienced by patients and have minimized its etiological significance. For example, the prevalence of incest was described in a major text of psychiatry (Freedman, Kaplan, & Sadock, 1976) as negligible, whereas subsequent research demonstrated the prevalence of this and other types of child victimization to be quite high (e.g., Gelles, 1978; Kilpatrick, Saunders, & Smith, 2003). This statement in a major textbook means that students were taught that child victimization was a negligible problem and is a strong indication that the trauma stories of millions of patients were never heard by generations of clinicians. This highlights how acceptance of PTSD into DSM III was as much driven by exploration of the effects of trauma by writers and the advocacy of activists than by the scholarship of professionals (Young, 1997).

THE SOCIAL AND SCIENTIFIC DYNAMICS OF THE 19TH-CENTURY ENLIGHTENMENT

More than any other psychiatric disorder, PTSD has been embroiled in public debate about its nature and causes that goes beyond mental health professionals (Shephard, 2003). A central reason is that PTEs such as wars, natural disasters, and accidents draw psychiatry and psychology into an interface with political and legal systems, which does not occur with other psychiatric illnesses. Also, over the last two centuries there has been a dramatic change in the social attitudes and capacity for empathy for victims. Scientific and technological advances that have allowed a more focused concern about the nature of pain and the consequences of suffering must be considered if the nature of traumatic stress is to be understood (McFarlane, 2000). The emergence of PTSD into the psychiatric nomenclature has probably been more influenced by these dynamic social, political, and technological changes than by the development of models of post-traumatic psychopathology by leading clinicians.

Many observers of human suffering in the 19th century were not medical professionals. Abolitionists who fought for banning slavery, reformers of prisons, and advocates for humane asylums for the mentally ill were enlightened public policy advocates. In addition, novelists who focused on both civilian and war trauma gave voice to the distress of their traumatized protagonists. It was in this environment that the costs of war and the shocking disability from work-related injuries arising from the industrialization of Europe and America evoked significant public attention (Trimble, 1981). This awareness was slowly acknowledged in legal and pension reforms. The importance of justice and legal protection acknowledged the need to protect individuals and provide care for them if they were injured by no fault of their own. Political, legal, and social reformers took up the cause, and this in turn demanded that medical professionals better understand the psychological dimensions of suffering and how to best manage them. This acceptance first emerged in accepting the legal need to compensate those who suffered psychological injuries because of the negligence of a third party.

COMPENSATION FOR ACCIDENTS

The Liverpool and Manchester Railway in England opened in 1830. The first accident occurred on the very day of this opening when a member of Parliament was fatally injured (Trimble, 1981). This incident became a focal point for those concerned about the risks of this dangerous new form of transport. Accidents remained a constant challenge and problem because of derailments and collisions. One of the victims was Charles Dickens, who described his symptoms as follows:

I am not quite right within, but believe it to be an effect of the railway shaking. . . . am curiously weak. . . . I cannot bear railway travel yet. A perfect conviction, against the senses that the carriage is down on one side comes upon me, with anything like speed, is inexpressibly distressing. (Trimble, 1981, p. 28)

Development of compensation programs for accident victims became the focal point of many observations about the impacts of trauma in the 19th century. In explaining compensation-related injuries, the medical professionals initially focused on the impact of the rapid deceleration at the point of collision and the musculoskeletal

consequence of the spine. A very influential early work was that of John Erichsen (1818–1895) at University College London, who addressed the impact of “injuries of the spine that may arise from accidents that are often apparently slight, from shocks to the body generally, as well as from blows inflicted directly upon the back” (Trimble, 1981, p. 9). He argued that the nature of the injury was concussion of the spine and concluded that “the primary effects of these concussions or commotions of the spinal cord are probably due to molecular changes in its structure. The secondary effects are mostly of an inflammatory character.” These ideas were highly influential in both Europe and the United States.

In 1883, Herbert Page, a surgeon to the London and North Western Railway, published a rebuttal to Erichsen in a volume titled *Injuries of the Spine and Spinal Cord without Apparent Mechanical Lesion*. His view was that concussion created unwanted anxiety in victims of minor accidents. He came to believe that the patient’s infirmity was, in reality, attributable to “symptoms of general nervous prostration or shock and pains in the back” (Trimble, 1981, p. 25), which later would be called whiplash. He believed that Erichsen had not considered adequately the possibility of “nervous” symptoms. His views were picked up, and the *Boston Medical and Surgical Journal* in the 1880s carried a series of papers related to “so-called concussion of the spine.” G. L. Walton, in 1883, summarized debates between railway spine and traumatic neurasthenia. Hence, a tension arose between whether this injury was due to organic change in the spine or whether it was a consequence of nervous shock. Page argued for a psychological origin, stating that “many errors in diagnosis have been made because fright had not been considered a bit self-sufficient” (Trimble, 1981, p. 26).

Similar investigations occurred in Germany. A further impetus to better understand the consequence of accidental injury came from the introduction of workers’ compensation legislation. The first chancellor of Germany, Otto von Bismarck, had to negotiate with the Socialists to bring about the unification of the German states, including Prussia (Macleod, 2019). An important negotiating strategy was the introduction of social benefits, including workers’ compensation. It was in this setting that Hermann Oppenheim in 1889 (Sequin, 1890) coined the term *traumatic neurosis*, which he saw as a functional problem produced by subtle molecular changes in the central nervous system. The challenge that remained was how to conceptualize the patient’s symptoms and reactions, which included both physical symptoms such as pain and ongoing fears and anxieties, which were also common features.

Intense interest in this question was reported in 1890 in the *Annual of the Universal Medical Sciences*, a major publication reviewing critical advances in medicine. The whole of Volume III dedicated to psychiatry was on the one topic, titled “Traumatic Neurosis.” The editorial by Edward Seguin (1890) began:

The detestable terms, “railway spine” and “railway brain”, are still employed by a number of authors, but apparently more with the object of clearly indicating the general classification of the cases they report than with the idea of proper scientific designations. It would do much towards finally setting the status of the topic if those terms (railway spine, railway brain, compensation neurosis) as well as the words “concussion” and “hysteria” were dropped. (p. N1)

Seguin argued that these terms should be grouped under the phrase *traumatic neuroses*. Debates about etiology focused on the relative importance of psychic shock as opposed to vascular changes. This was a thriving field embraced by many clinicians from quite

varying backgrounds, and they reached a consensus that was remarkably similar to the position that DSM-III adopted.

The Crimean War (1853–1856) was fought following the invention of the telegraph and the camera (Ignatieff, 1998). For the first time, distress and the suffering of soldiers was brought to public attention. The British public became outraged at logistic and command failures of the war, such as the Charge of Light Brigade where a cavalry charge into an artillery battery led to terrible carnage. Many troops needlessly died of disease, undernutrition, exposure, and sepsis, which evoked further condemnation of the government.

After an 1855 report by a Royal Commission highlighted the army's blunders in the Crimea, the secretary of war gave Florence Nightingale authority to take a group of nurses to the Scutari Hospital in Istanbul. Her innovations included placing partitions between beds when soldiers were having amputations, so that colleagues did not have to observe the anguish and horror of the procedure, which was often done without anesthesia (Small, 1999). She was also a very able statistician and documented the horrific neglect of the injured and diseased soldiers, as well as needless pain due to prohibition of anesthesia during amputations. After returning to England, she retired to her bedroom and seldom ventured beyond for 9 years. It is probable that she was suffering from what would now be called PTSD because of what she had witnessed. Only after the extreme suffering of hospitalized soldiers was publicized did their psychological suffering become a more salient issue. The medical profession's neglect extended to any serious study of the psychological consequences of war.

Leo Tolstoy (1855/1986) was an artillery officer in the Russian Army who participated in the siege of Sebastopol in the Crimea in 1854, an experience that became the basis for his *Sebastopol Sketches*. Each of the three short stories in this work contained a description of the medical staff amputating a mutilated limb. Unlike the British, the Russians used anesthesia. His epic work *War and Peace* (Tolstoy, 1867/2016) was modeled on his psychological synthesis of what he had observed about war in the Crimea. He articulated the private humanity and suffering in the face of the confusion of battle that was a further beginning to consideration of the costs to the men who fought. He reflected on how the reality of war was not what history captured:

All these odd and to us incomprehensible discrepancies between the facts and the historical accounts arise only because the historians writing of these events wrote a history of the fine phrases and feelings of the various generals, and not a history of the events themselves. (p. 1283)

The U.S. Civil War (1861–1865) was the first conflict to illustrate the horrors of industrial warfare on a large scale. The death toll of 204,000 men from battlefield injuries and 388,000 from disease highlights the extraordinary suffering, which left a legacy of profound loss to the nation. It was not only the lingering cost of battlefield injuries that preoccupied the medical profession at that time. Important observations were also made about the psychological suffering, which was described in terms of a range of syndromes, including soldier's heart (Da Costa's syndrome) and nostalgia, as well as the scourge of narcotic addiction following attempts to treat both psychological and physical pain (Trimble, 1981). This background likely explains the U.S. Army's better preparation when it finally entered World War I with regard to the probable psychological costs and the need to have effective systems in place. This readiness was in stark contrast to the situation of the British and German armies, who were woefully unprepared when the war began.

Jean-Henri Durant, a social activist and winner of the first Nobel Peace Prize in 1901, had been a key witness to the horrors of war. He witnessed the battle of Solferino in 1859, which was fought in Italy between the Sardinian Army and the French (Ignatieff, 1998). He was shocked and horrified by the sight of the injured and dead who had been left on the battlefield without care or rescue by their armies. In the aftermath of the battle, he recruited local citizens to bring assistance to those casualties who were in a grievous state. This led him to lobby for the Geneva conventions and to establish the International Red Cross, for which he was ultimately awarded the Nobel Prize.

In France, the fervor for political freedom and democracy that followed the Franco-Prussian War of 1870–1871 was an important backdrop to the emerging interest of clinicians such as Jean-Martin Charcot and Pierre Janet in the phenomenology of trauma. Charcot, in Paris, was one of the most famous neurologists of the time, and Janet was a medical graduate who studied hysteria under Charcot.

One of the important debates that emerged was about the role of women in a democracy, and this led to the first international congress of the rights of women, which was held in Paris in 1879. One discussion focused on discrediting many of the superstitious beliefs about women's maladies and on defining the role that medicine had in studying these complaints. Charcot investigated the role of hysteria in the miracles of the Middle Ages (Charcot & Richer, 1881/1984). His interest in hysteria was partly driven by his political interest in human rights. France now entered a state of self-examination where it was open to exploring the costs of war and social trauma, including the sexual abuse of women and accidents.

Hence, the emergence of an intense interest in the effects of psychological trauma in the last decades of the 19th century marked a combination of an increasing awareness of the humanitarian cost of war and the civilian accidents driven by the direct experience of trauma. The scientific revolution that was changing medicine at that time also permitted suffering to be studied and documented. Another factor that influenced the conceptualization of the effects of trauma and its symptoms was the overriding question of how to conceptualize invisible illnesses when there was no observable neural pathology.

MODELS OF DISEASE IN THE 19TH CENTURY

The beginning of modern medicine was very much influenced by René Descartes's dualism. He argued that the mind was separate from matter and that these were two separate independent worlds. This dualism had been encouraged by Christian theologians to avoid conflict with the emerging world of science. However, it led to considerable confusion in understanding the PTSD construct, particularly when psychiatry began to separate from neurology at the end of the 19th century.

Many descriptions of what would now be thought of as PTSD in the 19th century involved an aggregation of both physical and psychological symptoms, such as concussion of the spine. In this context, an important controversy that influenced the conceptualization of PTSD was whether it was a neurological entity with a distinct underlying structural pathology (Trimble, 1981) or another category of disease that was viewed as disturbance of nerve power or neurosis (Trimble, 1981, p. 38). This in turn led to the concept of functional disorders. William Gowers (1893/1970), in an influential textbook, argued for the categorization of neurological disorders as either organic or functional disorders, where functional disorders were thought of in a physiological

sense. Examples of functional disorders were migraine, chorea, and epilepsy. Trimble concluded:

Molecular changes . . . probably constitute the morbid process in many diseases that are commonly classified as “functional. . . . The primary derangement is in the higher cerebral centers, but the functions of the lower centers in the brain, spinal cord, and of the sympathetic system, may be secondary disorder. (Trimble, 1981, p. 40)

This construct argued for the psychophysiological underpinnings of many presentations and was consistent with Oppenheim’s hypothesis that traumatic neurosis was caused by molecular changes in the central nervous system. However, the intersection with hysteria began to cause confusion of terminology. Page, in his examination of patients assessed after railway accidents, came to the view that many of the symptoms were due to nervous shock and hysteria. In this context, “functional” came to have a dramatically different meaning. Charcot, prior to his death in 1893, developed an intense interest in posttraumatic neuroses and their relation to hysteria. He brought the same intellectual discipline to the study of hysteria as he had used in his research on organic neurological disease. He concluded that hysterical states had a neurophysiological underpinning related to abnormal functioning of the brain. He believed that railway spine and railway brain were very often the result of hysteria. He continued to use the word *functional* in the physiological sense, concluding about the etiology of hysterical upper limb paralysis that “[w]e have here unquestionably one of those solutions which escapes our present means of anatomical investigation in which, for want of better term, we designate dynamic or functional lesions” (Trimble, 1981, p. 45).

Janet and Sigmund Freud, both of whom studied under Charcot, increasingly focused on the role of unconscious factors in the development of hysterical symptoms. Janet rejected a neurological theory of hysteria as well as the notion that the symptoms were faked; rather, he proposed that hysteria was a “psychogenic” disease. The concept of psychogenic illness emerged early in the 19th century and was related to conditions “due to activity of mind” (Trimble, 1981). Use of the word *psychogenesis* had become increasingly imprecise and blossomed into popular usage with the writings of Freud.

When Freud lectured about Charcot’s ideas, he argued that posttraumatic neuroses equated to hysteria, leading to heated disputes with colleagues. He developed his ideas in his collaboration with Josef Breuer and published the lecture, “On the Psychological Mechanisms of Hysterical Phenomena,” in which they concluded:

Trauma does not simply act as a releasing agent for symptoms. Rather, psychic trauma or more precisely *the memory of the trauma acts like a foreign body* which long after entry must continue to be regarded as the agent that still is at work . . . a psychical pain that is remembered long after the event. Hysterics suffer mainly from reminiscences. (Breuer & Freud, 1955, p. 58)

Freud went on to develop his structural model of the mind and the critical role of the unconscious and thereby redefined the meaning of psychogenic. This construct was where the fracture between psychiatry and neurology was defined, particularly in those who became psychoanalysts, until the publication of DSM-III.

Hence, the term *functional* came to have a psychological meaning. Physician Gordon Kamman (Trimble, 1981) stated that posttraumatic neurosis was psychogenic and that it resulted from conflicting forces or drives within the personality structure of the

individual. This was viewed as a reaction rather than as being related to the event or injury caused. Symptoms were viewed as conflicts between internal systems of the mind and failed adaptations to a new environment. Words such as *functional* and *psychogenic* became so distant from their original definitions that they lost any conceptual utility. Progressively, the view emerged that psychiatric illnesses such as PTSD were functional, which in turn took on a pejorative undertone. They had lost any connection with their psychophysiological underpinnings as characterized by the emerging field of neurophysiology. Modern neuroscience has shown that any attempt to distinguish functional from organic symptoms is meaningless.

However, prejudice regarding the use of these words in relation to the effects of traumatic stress continued into the 20th century. A legacy was to focus on psychological mechanisms in traumatic neurosis at the exclusion of the centrality of the physical symptoms to the patient's experience. Ignoring the centrality of these physical symptoms in PTSD is ironic, given that one of its original formulations was as railway spine. Thus, the dominance of psychoanalysis in the 20th century led to psychophysiological dysregulation being largely ignored as being part of traumatic neurosis. This was partly a consequence of Charcot's successor, Joseph Babinski (1857–1932), who chose to diminish his mentor's legacy. Babinski postulated that the symptoms Charcot observed in posttraumatic neuroses were a consequence of suggestion created by hypnosis (Bailey, 1918).

The legitimacy of traumatic neurosis was always subject to debate when compensation claims were instituted. Questions were raised about how malingering and suggestion were mechanisms underlying the clinical presentations assessed in litigation settings. Much of the early attention on traumatic neurosis was in the context of compensation cases involving railway accidents. The defendant's case depended on casting doubt on the credibility of the litigant. As the field became linked to the study of hysteria and the role of the unconscious, the influence of secondary gain received increasing attention. This added to suspicions about the legitimacy of symptoms, particularly when the individual's motivation was in question. This dynamic played out in the different conceptualizations of PTSD in World War I and the intellectual battles that took place in deconstructing shellshock. Were the mind and the brain separated? Was this a physical or psychological injury, or was shellshock primarily a motivational problem?

THE STUDY OF PATHOGENESIS AND THE ROLE OF TRAUMATIC EVENTS

Models of etiology rapidly developed in medicine in the second half of the 19th century. The basic mechanisms of pathology, such as healing, inflammation, and infection, were described, but the cause of many illnesses remained obscure. Moreover, even when etiological agents were identified, little could be done to modify their effect. The role of environmental factors in illness was still in its infancy. In contrast, Charles Darwin's *On the Origin of Species*, published in 1859, which set out the theory of evolution, had a dramatic impact on theories of what caused mental illness. The hereditary factor was viewed as a critical causal feature of these illnesses (Macleod, 2019). Darwin's observations about the phylogenetic nature of emotion among patients in mental asylums added to his influence about the origins of mental illness. Hence, the predominant paradigms focused on the host rather than the nature of the external environment that led to symptom formation. This formulation was particularly influential in the debates regarding the cause of psychiatric casualties suffered in World War I.

Importantly, at this time Russian Nobel Prize winner Ivan Pavlov (1849–1946) was making important observations about conditioned reflexes. He had an interest in the physiology of gastric function and the saliva gland. In the course of this research, in 1901 he described the phenomenon of classical conditioning and involuntary reflex actions. This work became the foundation of modern behaviorism. At the time, this work did not have a significant influence on the common understanding of the nature of the response to PTEs, or early 20th-century theories about the etiology of traumatic neurosis. However, classical conditioning was later applied by psychologist John Watson and psychiatrist Joseph Wolpe in the development of key behavioral treatments (Monson et al., 2007). Psychologists Dean Kilpatrick, Lois Veronen, and Patricia Resick (e.g., 1977, 1979) were the first to apply the concept of classical conditioning to understanding fear and anxiety in victims of rape. Their work influenced the subsequent development of fear-conditioning models of PTSD as well as cognitive-behavioral treatments for PTSD (Monson et al., 2007).

The original view of the pathogenic agent in traumatic neurosis was nervous shock. However, there was little discussion of the exact mechanisms through which it exerted its effects. Charcot's previous work led to postulation about possible mechanisms, including dissociation and the importance of traumatic memory. Janet's 1889 doctoral dissertation made a seminal contribution to the origins of modern traumatology. He hypothesized that the symptoms of hysterical patients were manifestations of a lack of synthesis, which dissociated their personality into different "systems of ideas and functions" (Janet, 1907). In many cases, traumatic experiences were seen as critical.

These ideas were further developed by Freud, who stated that the traumatic event was responsible for neurotic symptoms. In most of his patients, the event identified was childhood sexual abuse. He then made a dramatic shift in 1897, rejecting his previous opinion. Freud's recanting of his earlier views had a dramatic impact on the acceptance and management of sexually abused children. Thus, according to Brown (1968), "Freud had to change his mind concerned with these supposed sexual seductions of childhood [as] from the accounts of relatives it seemed clear that the patient was either lying or imagining an event which had never happened" (McFarlane, 2000, p. 54). This recanting of Freud's original formulation and denial of the reality of sexual abuse unraveled the critical role of the memory of PTEs in adult psychopathology for 80 years.

Mental health practitioners continued to accept Freud's assertions, despite the accounts of sexual abuse reported by millions of patients. As a result, clinicians had difficulty acknowledging the existence of trauma. Based on the theoretical assumptions of psychoanalysis, many clinicians assumed that the symptoms caused by the experience of traumatic events were due to existing personality traits. This shift in Freud's views and the growing influence of psychoanalysis, combined with Babinski's negative view of many of Charcot's observations, was a critical historical turning point. Blocking the development of the inquiry into the impact of traumatic events had catastrophic consequences both for generations of patients and for the development of this area of psychiatry and psychology.

WORLD WAR I AND THE SHELLSHOCK DEBATE

Human imagination failed to prepare the world for the consequences of the carnage of World War I. In the postwar years, countries were preoccupied with the grief associated with the death of between 22 and 25 million men in their prime. Those who survived

without physical wounds were considered the lucky ones, and hence psychological injuries were not a predominant focus of concern. The estimated 50 million killed by the 1918 Spanish influenza pandemic added to the sense of carnage and loss.

At the beginning of the war, a fundamental question that confronted the medical officers was whether inability to function in battle was a moral or mental problem. Was it simply a matter of conscious will when individuals broke down? This question was described as “the psychic no-man’s land that separates malingering from hysteria and which links free will with determinism” (Butler, 1943, p. 43). The absence of a clear diagnostic framework was fertile ground for the acceptance of the emerging concept of shellshock. The various diagnostic labels used included traumatic neurasthenia, hysteria, disordered action of the heart, and shellshock. The medical profession was confronted with soldiers who broke down in battle. The focus was on the nature of acute disorders and how to manage them, with the primary goal being to return soldiers to active duty (Salmon, 1917).

Despite the enormity of the exposures and losses, a continued debate existed about the cause of these psychiatric disorders rather than about the role of emotions such as fear and horror. Rather, debate continued as to whether it was due to the “seed” rather than the “soil.” Arthur Butler (1943), who wrote the history of the Australian Medical Corps, summarized the issue as “the [preexisting] nervous and moral constitution of the force and of the individuals comprising it rather than that particular kind of strain to which they were subjected—was the essential element in determining the total amount of nervous breakdowns” (p. 89). Hence, despite the extraordinary conflagration experienced in battle and the strains of 4 years of fighting, the view that individual vulnerability was the critical diathesis leading to war neurosis remained the predominant one.

The problem of acute mental casualties also focused debate on psychogenic and functional disorders. Speculations about the role of motivation and courage were rife. This focus prevailed despite the carnage of trench warfare, the brutality of intense artillery barrages, and the constant threat of being poisoned by chemical agents. Chemical weapons also produced an element of psychological warfare in which there was a constant threat of these invisible agents. In this context, the debate about the concussive effects of being exposed to shells exploding emerged. As with railway spine, the debate was about whether the critical issue was the physical effect of the explosion or the threat of death and injury.

Myers (1915), the British physician who first published research on shellshock, attributed the symptoms to the concussive effects of exploding shells. This formulation viewed an external agent as the cause of symptoms rather than individual vulnerability. This theory had obvious appeal to soldiers, but the military hierarchy saw the inability of the medical corps to prevent the popularization of concepts such as shellshock or “war neurosis” as “a devastating menace,” fearing that it would lead to “military and social exploitation and mass suggestion” (Butler, 1943, p. 93).

The public accepted the reality of shellshock, but many doctors argued that it provided too easy an exit from the battlefield. These views were challenged by the soldiers, particularly those who became renowned war poets in Great Britain, such as Siegfried Sassoon (1983):

How many a brief bombardment had its long-delayed after-effect in the minds of these survivors, many of whom had looked at their companions and laughed while inferno did its best to destroy them. Not then was their evil hour; but now; now, in the

sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. (p. 51)

Sassoon's account highlighted the fact that many soldiers who had bravely fought broke down after battle. Hence, the concept of shellshock went beyond its original formulation, and this created considerable consternation. A battle emerged between neurologists and psychiatrists about "the no-man's land between neurology, the medicine of the brain, and psychiatry, the medicine of the mind" (Butler, 1943, p. 93). This rivalry did little service to those who were suffering, for the military command continued to see this both as an urgent disciplinary problem and a reflection of the soldiers' failure to manage the fear of battle.

The Challenge of Dealing with Secondary Gain and Prolonged Disability

The challenge of maintaining the fighting force in the face of the rising number of casualties became an increasing preoccupation of the medical services. Shellshock implied the need to remove individuals from the battlefield in order to prevent further injury. Similar discourse among professionals occurred on both sides of the war, partly due to a regularly published letter in the *Journal of the American Medical Association* that kept the English-speaking world abreast of the thinking of German psychiatrists (Macleod, 2019). In 1916, German psychiatrists, led by Emil Kraepelin, decided that a traumatic neurosis diagnosis was not in the national interest. They argued that having a name/diagnosis caused disability, reduced the will to fight, and showed that symptoms were not the consequence of combat (Macleod, 2019). Although the term continued to be used, this politically driven consensus statement had the effect of largely banishing traumatic neurosis from the psychiatric nomenclature until DSM-III reintroduced the diagnosis as PTSD in 1980 (APA, 1980).

Given this conclusion, the challenge became how to limit secondary gain. If a soldier broke down, the aim of the doctor was to stop him from falling into the trap of accepting "the insidious motivation" of "defeat and dependence" (Butler, 1943, p. 103). Delaying diagnosis was one strategy, and the label of the "not yet diagnosed: nervous" emerged. The absence of a diagnosis was supposed to promote early recovery and a rapid return to duties (Salmon, 1917). In adopting this practice, medical officers prioritized responsibilities to military command rather than acting in the best interests of the patient, thereby neglecting the risks of symptom exacerbation through further combat exposure.

As the end of the war approached, the prevailing view remained that individual vulnerability was the primary cause of psychiatric casualties and that inadequate selection had failed to exclude those who could not cope with war service. Lack of discussion about the risk of cumulative combat exposure during World War I is one of the striking lacunae of the literature of the era. Medical ideas of causation also assumed that any adverse effects of battle would be immediately apparent. The idea of a delayed onset of morbidity was not accepted in the medical literature. However, once the war ended, the numbers of those who could not function and sought pensions increased.

In general, psychiatry and psychology were at a loss to explain the delayed emergence of psychopathology. Rather, an alternative discourse emerged which was notable in the way that pension claims were managed. Delayed presentation was seen to be a consequence of suggestibility (Bailey, 1918). Exaggerated disability and compensation neurosis were dominant rubrics that were used to dismiss emerging symptoms. The

individual was stigmatized in his suffering as being poor “seed” rather than having been injured by the horror of war. However, an interesting strain developed between views of the medical establishment and broader popular perceptions of this issue. This matter remained an ongoing controversy in which social attitudes favored an understanding of the veterans’ suffering, but concerns about the cost of pensions fueled prejudice in other circles.

Many of these issues were revisited after the war when the results of an inquiry into shellshock by the British War Office was published. The Lord Francis Southborough Committee (1922) concluded that shellshock was not due to concussive injury. The psychogenic view of etiology had evolved to the position that psychological mechanisms were an unconscious escape into disease. Retreat into illness provided a solution to the unendurable emotional tension faced by the soldier. Secondary gain was seen to be acceptance that this was a wound that allowed removal from duty (Wessely, 2006). Ultimately, it was accepted that war neurosis/traumatic neurosis was not a consequence of some immediate physical “shock to the brain that had led to microscopic neurological lesions” (Butler, 1943, p. 99). However, the burden of proof in the minds of many soldiers was weighted between acceptance of vulnerability due to these psychological constructs (because of the stigma of mental illness) versus disability due to a direct injury.

There were few certainties and much debate as to what the most effective treatments were. Medical officers were generally “left to work out their own salvation” (Butler, 1943, p. 104). Treatments ranged from hypnosis to galvanism (e.g., electrical shocks), rest, and psychotherapy. Notable contributions were made by clinicians such as W. H. R. Rivers, who saw that repression was the central mechanism of the failure to process the traumatic memory. Equally, he saw that it was the attempt to keep the traumatic event at bay, rather than the primary experience at the time of combat, which was critical to the emergence of later symptoms (Rivers, 1918).

In retrospect, historical observers did not have models or tools to measure the dysregulation of the function of neurohormonal systems and the effects of conditioning on neural functioning. The fact that certain underlying neurobiological processes underpinned the emergence of psychological symptoms due to the horrendous trauma of warfare was not considered. The mind–body split remained supreme based on an overly simplistic dichotomy of a biological/neurological illness or a disorder of mental mechanisms. The latter dominated due to the ascendancy of Freudian psychology.

THE INTERWAR PERIOD

The end of the war brought a period of reflection and memorialization of the dead. The challenge of dealing with injured soldiers led to building the veterans’ health systems in the United States, Canada, and Australia. It had been expected that the psychiatric casualties would recover with the end of the war. However, with the passage of time, many soldiers who coped with the heat of battle became unwell. Progressively, the number of pensions issued for psychiatric illness increased. For example, between 1916 and 1920 in the United Kingdom, only 4% of pensions were for “neurotics.” By 1932, 36% of pensions in the United Kingdom were for psychiatric cases. By 1942, neuropsychiatric cases represented 58% of all the World War I veterans on pensions in the United States (Micale & Lerner, 2001).

There was minimal recognition of the delayed impact of combat exposure, and any delayed problems were attributed to secondary gain. Pension systems were blamed, and benefits were reduced or terminated altogether, as occurred in Germany. In 1938, the United Kingdom determined that there would be no pensions for psychiatric injuries in future wars. In Germany, the Nazis began exterminating psychiatric patients, many of whom were World War I veterans (Jones & Wessely, 2001). In short, Germans failed to consider the prolonged impact of war trauma on patients because they were reminders of defeat.

The interest of the psychiatric profession waned, and “the limited ability to cope with combat was deemed the result of faulty personality development and thus conformed to the psychoanalytic model of the psychoneuroses and was so generally diagnosed” (Glass, 1974, p. 802).

Veterans continued to advocate for those suffering because of their service. Increased concern was voiced about the premature mortality and general physical debility of those who had fought, and this led to the claim that there was a ‘burnt-out’ soldier syndrome. A large-scale epidemiological study in Australia found that combatants who had fought on the Western Front had a decreased life expectancy of 4 years (Butler, 1943). Despite these observations and the continued increased presentation of delayed-onset PTSD, as it would now be known, mental health professionals had little interest in the trauma field. Rather, the suffering of the soldiers and the exploration of their experience were captured by war poets and authors, including Robert Graves, Siegfried Sassoon, and German veteran Eric Marie Remarque (1987), who wrote the great World War I epic, *All Quiet on the Western Front* (1929). These writers gave voice to the suffering of those who fought, and they captured the phenomenology of their experience.

WORLD WAR II

When World War II began, Allied forces were unprepared for the psychological casualties, and it took months to relearn the lessons of World War I. U.S. forces undertook major screening programs, but these programs did not stop the problem of acute combat breakdowns (Glass, 1974). A direct result of overreliance on screening was that there was little preparation for an overwhelming incidence of psychiatric disorders. During the Tunisian campaign in 1943, the U.S. Army suffered large numbers of psychiatric casualties who were generally lost to fighting units. More than 2 years elapsed before sufficient organizational and operational capability was developed to adequately deal with the large incidence of psychiatric disorders.

One consequence of the continued reluctance to diagnose mental disorders was seen in the United Kingdom’s Royal Airforce. A tour of duty was 30 missions, based on a calculation that there was a 50% chance of being shot down after 30 sorties. If an airman could not fly due to a psychiatric disorder, it was not diagnosed, and he was deemed to show “lack of moral fibre” (McCarthy, 1984). This label was highly stigmatized and led to loss of rank and dishonorable discharge. This policy reflected the idea that secondary gain was a critical driver of symptoms and impairment, not the cumulative stress of battle (Wessely, 2006).

World War II psychiatrists did begin to reconsider these views because of research on the epidemiology of combat stress casualties. Prospective studies by Stouffer and colleagues (1949) demonstrated that units with good morale and leadership had fewer

combat stress casualties than those without, controlling for combat intensity. A direct relationship was also found between combat intensity (as measured by rates of wounded and killed in action) and psychiatric casualties (Beebe & Apple, 1958). “New” or inexperienced troops were more likely to become a psychiatric casualty, but with increasing exposure to combat, after one or two combat months, older troops were also likely to suffer from combat stress.

While the focus was on acute combat stress reactions, Grinker and Spiegel (1945) proposed that some people develop excessive responses under stress and that such responses are often transformed into prolonged disorders. They highlighted the lack of a clear diagnostic system: “The clinical description of the neurotic reactions to severe combat stress is thus a passing parade of every type of psychological and psychosomatic symptom, and of maladaptive behavior” (p. 82).

In the postwar period, extreme stress was accepted as an important determinant of acute symptoms with the inclusion of “gross stress reaction” in DSM-I (APA, 1952). However, the need for a separate category to account for the chronic disorder remained elusive. In DSM-II (APA, 1968), a shift toward including less severe events was reflected in the category “transient situational disturbance.” This diagnosis was used to describe acute symptomatic distress following a range of aversive events, whereas more prolonged disorders were categorized as anxiety or depressive neuroses. The suspicion remained that diagnosis led to disability through suggestion, and the term *compensation neurosis* was synonymous with traumatic neurosis, despite the systematic evidence about the long-term effects of traumatic stress.

POST-1945

When the war ended, there was again no anticipation of the continued burden of psychiatric casualties. The expectation remained that the effects of combat were acute and would resolve with effective frontline psychiatry. There was little interest in studying the long-term effects, except for a few enlightened clinicians such as Abram Kardiner, who characterized traumatic neurosis as a physioneurosis (Weisaeth, 2007). Albert Glass, who wrote the main report on the psychiatric casualties of World War II in the U.S. forces, commented, “Curiously, during the early postwar years, as following World War I, military psychiatry, like civil psychiatry, ignored the lessons of wartime experiences. Instead, attention was focused in the then prevalent psychoanalytic concepts and practice” (1974, p. 804).

An intense interest in the acute effects of stress remained, however, as reflected in the categories “gross stress reaction” and “transient situational disturbance” included in DSM-I and DSM-II. Many psychiatrists had seen service in World War II, including Thomas Holmes and Richard Rahe, who developed the life events research field. However, this body of work did not differentiate the effects of events such as unemployment or divorce from traumatic stressors. It did lead to bereavement research, and early pioneers such as Colin Murray Parkes and Beverly Raphael developed interventions to address the morbidity of loss (Weisaeth, 2007).

This work in the area of bereavement was one of the early origins of disaster research that contributed to the emerging interest in PTSD. While the earliest studies of disasters were by Edouard Strielin, who documented a Swiss mine disaster and the impact of the Messina earthquake, there had been little accumulated experience from the investigation of these events (Weisaeth, 2007). In the United States, several tragic

nightclub fires gave new impetus to this field and to the role of crisis intervention in assisting victims. A turning point of interest was the Buffalo Creek disaster in 1972, documented by James Titchener, who conducted a long-term follow-up of the affected community in the context of the litigation that followed for compensation from the mining company responsible for the dam's collapse (Weisaeth, 2007).

In the aftermath of World War II, repatriation of refugees highlighted the horrors of the Holocaust and the need for some long-term reparation. Pioneers of the field who were survivors included the psychiatrist Henry Krystal, who fought for adequate pensions for Holocaust survivors from the German government (Weisaeth, 2007). In the Netherlands, resistance fighters who had been brutally treated by the Nazis sought long-term recognition and were assisted by Professor Jan Bastiaans, another veteran. In Norway, Leo Eitinger, who had survived Auschwitz, studied the impact of stress on survivors of the Holocaust as well as on merchant mariners in the convoys that traversed the Atlantic Ocean during the war. His research demonstrated the long-term effects of war on the mental and physical health of both groups (Weisaeth, 2007). Because of this work, Norway emerged as a leader in understanding the effects of disasters and trauma.

ADVOCACY MOVEMENTS IN THE 1960s AND 1970s THAT CATALYZED THE BIRTH OF PTSD IN DSM-III

The Vietnam War and Its Aftermath

The political and social turmoil surrounding the conduct of the Vietnam War and the treatment of veterans led to a critical turning point in the traumatic stress field. The rates of psychiatric casualties were not anticipated since tours of duty were limited to a year. Upon returning to the United States, veterans who sought treatment from the Department of Veterans Affairs (VA) were often humiliated and felt that their struggles were not dealt with empathically (e.g., Scott, 1990; Shatan, 1973).

In the context of the Vietnam War protest movement, the VA began to set up "rap" groups, which were essentially a self-help movement. A group of psychiatrists and psychologists, some of whom were themselves veterans of the war, began participating and engaging with these groups; among them were Charles Figley, Sarah Haley, and Art Blank. (Blank later went on to become the director of the Vietnam Veterans Readjustment Counseling Service.) Other political activist clinicians, such as Robert Lifton and Chaim Shatan, became actively engaged and advocated for the Vietnam veterans. One of the inadequacies of the veterans system was its essential denial and lack of curiosity about the nature of stress response syndromes. Veterans were so distrustful of the DVA system that they demanded separate services.

The Women's Movement

The National Organization for Women (NOW) was founded in the United States in 1966. In the late 1960s and early 1970s, speak-outs and consciousness-raising groups organized by NOW and other feminist groups provided women with the opportunity to discuss problematic issues in their lives. A common theme was the devastating impact of sexual and physical violence against women and children. This issue focused attention on the abysmal treatment of victims of these crimes by the criminal justice system, health care professionals, and society in general. Freud's legacy had contributed to the

denial of child abuse and sexual violence and the lack of interest in the topic by most researchers and mental health professionals. To address the problem of rape specifically, feminist grass roots activists established the first four rape crisis centers (RCCs) in the United States in 1972. By 1979, every U.S. state had at least one RCC (Koss & Harvey, 1987). In 1978, the National Coalition Against Sexual Assault was founded to advocate for sexual assault prevention, services, and victims.

Anti-rape activists lobbied the U.S. government to pass legislation appropriating funds to support RCCs, but the public policy process worked in mysterious ways. A bill was enacted into law in 1975 that established the National Center for Prevention and Control of Rape (NCPCR) within the National Institute of Mental Health, but it did not provide funds for RCCs to deliver services. Instead, the NCPCR's mission was to provide funding for rape research. As Koss (2005) notes, NCPCR funding had a profound effect on the quality and quantity of rape research during its existence from 1976 to 1987. Prior to 1973, only 16 articles on rape had been published in the English literature. From 1974 to 1989, there were 453 such publications. The first NCPCR grant was funded in 1976, and 58 grants were funded as of 1981 (NCPCR, 1981). Many more grants were funded from 1981 until the NCPCR and its funding for rape research were abolished in 1988 upon the recommendation of the politically conservative Reagan administration (Koss, 2005). Two historical lessons from the NCPCR are that its existence and successes would not have been possible without anti-rape activists from the women's movement and that even highly successful programs are subject to elimination by the vicissitudes of politics.

Many influential individuals in the PTSD/traumatic stress field got their start in rape research funded by the NCPCR. A partial list of these pioneering traumatic stress researchers includes Susanne Ageton, Judith Becker, Ronnie Janoff-Bulman, Karen Calhoun, David Finkelhor, Edna Foa, Mary Harvey, Judith Herman, Dean Kilpatrick, Mary Koss, Patricia Resick, Barbara Rothbaum, Murray Strauss, and Lois Veronen. Work done by these pioneers provided theories, data on the prevalence of rape and its mental health consequences, and treatments for these problems that provided justification for the PTSD construct in DSM-III and that advanced the traumatic stress field.

Battered Women and Child Abuse

The woman's movement also highlighted the problem of family violence, much of which was directed at women, as well as the devastating mental and physical consequences of such violence. These observations by activists were confirmed by researchers who provided sound data documenting the extent of these problems (e.g., Gelles, 1980; Gelles & Straus, 1979; Walker, 1978). In 1978, the National Coalition Against Domestic Violence was established to advocate for battered women's shelters. Victims of these experiences described symptoms consistent with what would be included in the PTSD diagnosis.

There was also a growing understanding about the rights of children and about the extent of child abuse. In the United States, C. H. Kempe and colleagues (1962) published a seminal paper about the "battered child syndrome." The suffering of children whose parents had been murdered was an area that began to explore the impact of traumatic loss on children, documented, for example, by the British child psychiatrist Dora Black (Weisaeth, 2007). A national advocacy group in the United States, Parents of Murdered Children, was formed in 1978 by parents whose daughter had been murdered. Lenore Terr (1981) carried out a seminal study of the impact of a school

kidnapping that occurred in 1976. Richard Gelles (1978) conducted the first national study in the United States documenting the high prevalence of parent-to-child violence. Again, many survivors described symptoms consistent with PTSD.

The Crime Victims Movement

Core beliefs of the crime victims movement included (1) that victims are frequently mistreated by the criminal justice system, (2) that victims should have the same rights as criminal defendants, (3) that victims suffer harm from crime as well as from being mistreated by the criminal justice system, (4) that harm from treatment by the criminal justice system should be mitigated, and (5) that harm from the crime should be remediated. The National Organization for Victim Assistance (NOVA) was founded in 1975 and brought together a broad array of individuals who approached this problem from many perspectives. NOVA members included criminologists, mental health professionals, members of the criminal justice system, legal scholars, and crime victims themselves.

The crime victims movement highlighted that crime produces psychological injuries as well as physical ones and that a barrier to cooperation with the criminal justice system is lack of assistance in dealing with the extreme stress of interacting with the criminal justice system. Descriptions of crime-related psychological injuries included many symptoms that subsequently were included in the PTSD diagnosis. Also highlighted was the importance of providing crime victims with enforceable rights to be notified about and participate in criminal proceedings, to make impact statements to the court about how they had been affected by the crime, and to receive crime victim compensation and restitution for crime-related injuries they had sustained.

This movement was incredibly successful in achieving public policy change. By the 1970s and 1980s, all 50 U.S. states had enacted a Crime Victims Bill of Rights. This was accomplished by building a potent public policy coalition to improve victim rights and services. The coalition included social progressives who supported improving victim rights and services because it was the right thing to do based on the human rights tradition and humanitarian ideals that demanded fair treatment for all people, including crime victims. It also included social conservatives who supported these changes because “getting tough on crime” was impossible without the cooperation of crime victims. These two factions agreed on virtually nothing else but were united on this one issue. The lesson this history teaches us is that we can accomplish more if we put aside areas of disagreement and ideological purity fights and focus on areas of agreement.

Other Key Contributors

A group of independent clinician-researchers understood the limitations of the existing formulations of traumatic stress and made important contributions (Weisaeth, 2007). Two individuals who had particular impact were Mardi Horowitz and Nancy Andreasen. Horowitz’s (1978) seminal work on “stress response syndromes” characterized the phenomenology of intrusion and avoidance, which are central to our understanding of PTSD today. Andreasen, best known for her prolific research on schizophrenia, conducted a series of studies in the early 1970s with patients who had sustained major burn injuries (e.g., Andreasen, Noyes, & Hartford, 1971). She reported that “traumatic neurosis” was the most frequent psychiatric complication in this cohort of burn patients. These observations, as well as her distinguished status in the academic medicine field and her familiarity with the emerging findings on the mental health

consequences of exposure to PTEs among civilians, would make her a key player in how PTSD was defined and explained in DSM-III.

PTSD IN DSM-III: HOW IT ALL CAME TOGETHER

DSM-III was published in 1980, but preliminary work on it began in the mid-1970s. It was a radical departure from its predecessors due to the recognition that more reliable definitions of psychiatric disorders and improved methods of diagnosis were needed. Scott (1990) provides a fascinating account of events that resulted in PTSD becoming a diagnosis that includes media accounts and personal interviews with many of the key parties who were involved. His account places a great deal of emphasis on the following. First, there was no diagnosis in DSM-II that captured the symptoms clinicians were seeing among Vietnam veterans. Second, a group of anti-Vietnam War clinicians (Sarah Haley, Robert Lifton, and Chaim Shatan) advocated strongly for inclusion of a new diagnosis in DSM-III that would address this deficit. Among their candidate names for this proposed new diagnosis were “post-Vietnam syndrome,” “post-combat disorder,” and “catastrophic stress disorder.”

Third, word got out that there were no plans to include any type of combat-related disorder in DSM-III, which prompted members of the antiwar clinicians group to contact Robert Spitzer, leader of the DSM-III revision process, to press him to include a diagnosis. Fourth, Spitzer was skeptical, citing opposition by prominent psychiatrists and researchers, including John Helzer and Lee Robins who concluded that no new diagnosis was needed. However, Spitzer agreed to appoint a six-person APA Committee on Reactive Disorders, with Nancy Andreasen as chair to report to the DSM-III Task Force. Spitzer served as a member, as did three antiwar supporters of a new diagnosis for veterans (Lifton, Shatan, and Jack Smith, an antiwar Vietnam combat veteran). The charge to Lifton, Shatan, and Smith was to provide convincing evidence to their fellow committee members that would justify a new diagnosis. They in turn engaged others from the Vietnam veterans groups, as well as Henry Krystal and William Niederland who had been studying Holocaust survivors, including those who had been in German concentration camps.

Fifth, Andreasen was the key figure in deciding whether there would be a diagnosis and in determining what its nature would be. Scott (1990) indicates that the antiwar members of the committee viewed her as the key vote. Andreasen describes herself as “the psychiatrist who was also the midwife at the birth of PTSD” (2004, p. 1323). In her account of these events, she did not favor a “post-Vietnam syndrome” because it was too narrow and because the types of symptoms that were being described occurred among victims of civilian trauma as well as veterans. Her work with burn victims clearly reinforced these views. Scott notes that the committee then began to broaden its focus to include extensive information about all types of stress disorders that already existed, much of which is described in this chapter.

Sixth, these justification efforts were clearly successful, and PTSD was born as an official diagnosis that included civilian as well as war-related trauma. Specific types of PTEs included rape or assault, military combat, natural disasters, accidental human-made disasters, or deliberate human-made disasters such as bombings, torture, and death camps. As noted previously, this was a stellar achievement because it united a previously fractured field and provided a strong foundation that facilitated rapid progress in the traumatic stress field. It can also be argued that the comprehensiveness of the

PTSD diagnosis and the diversity of the traumatic stress groups who supported it made PTSD more resilient to attacks from critics than its narrower precursors had been.

CONCLUSIONS

PTSD science and practice exploded after PTSD was included in DSM III. The traumatic stress field has also had far-reaching effects beyond clinical practice, but it emerged as an entity, probably as much due to the voices of many groups of victims and survivors (some of whom were health professionals themselves) as because of mainstream health professionals. Delayed acceptance of the PTSD diagnosis was due to fear of suggestion and inappropriate compensation seeking. Mainstream psychiatry and psychology failed to document the suffering and impact of traumatic stress for complex reasons. The traumatic stress field has changed the landscape of many domains outside mental health, such as public policy, human rights, public health, cinema, and literature.

However, many age-old dilemmas remain. The challenge of how to incorporate the neurophysiology, neurochemical, cognitive, and psychodynamic processes into a unified whole remains, particularly as current diagnostic criteria do not fully capture the range of physical symptoms that were central to the initial descriptions of traumatic syndromes. The field has also documented the cumulative effects and prevalence of PTEs as a major public health challenge that affects many more people than those who develop PTSD. Furthermore, the impacts of traumatic stress go beyond PTSD and are central to the range of psychiatric morbidity. History teaches us that minimizing the impact of trauma fails those that health professionals are supposed to serve. Psychoanalysis was a major force driving this denial, which arose from Freud's recanting of his earlier observations about child abuse. Seeing the reality of the suffering arising from traumatic events allows clinicians to advocate for the broader social and political changes required to ensure that we live in a society safe for all.

We must be mindful that PTSD is widely accepted now, but forces always exist that minimize traumatic stress and its consequences for a host of reasons. The traumatic stress field is always in peril, so we must remember that numerous social and political advocates shaped the PTSD construct and made it a mental health/public policy priority. These forces united to advocate for inclusion of PTSD in DSM-III. Building and maintaining broad coalitions that extend beyond the mental health field are essential to ensure that traumatic stress remains a priority and does not, once again, fade away into the mist of the forgotten.

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