Acute and Delayed Posttraumatic Stress Disorders: A History and Some Issues

This issue of the *Journal* features stress disorders as its theme. The study of the psychological and emotional consequences of stress has become a burgeoning and important field in psychiatric research and treatment. In fact, the diagnoses of posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) are now so frequently made that one wonders how we once got by without them.

The stress syndromes that we refer to as PTSD and ASD have a very long descriptive history. In general, their early history was closely linked to the experiences that soldiers suffered in combat. Before a diagnosis existed, many features of the syndrome were well-described in literary form in *The Red Badge of Courage*. The terrible carnage of trench warfare during World War I led many young men to return home deeply traumatized, and this led in turn to systematic descriptions of the syndrome under names such as "shell shock" or "combat fatigue." World War II was, however, the catalytic event that led to the creation of a formal diagnostic category to refer to this syndrome: Gross Stress Reaction. World War II for the first time brought together soldiers, psychiatrists, and other medical personnel from all over the country, giving them an opportunity to discover the many things that they had in common and also to recognize the ways that they differed. Socially, our great melting pot received yet another incentive to continue to melt—and to meld together all the diverse components of our society. (The World War II musical, *Oklahoma*, celebrated this fact—watch it again some time in the context of our current world situation.) On the medical and psychiatric scene people discovered that they did not always share a common vocabulary with which to discuss the syndromes and diagnoses observed in their patients.

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After the war ended, the Veterans Administration (VA) developed a diagnostic manual, which provided the incentive for the APA to create its own first manual: DSM-I. The manual was very concise, but it included a diagnosis that covered victims of stress: Gross Stress Reaction. During that post-war era and after, psychiatrists also began systematic investigations of the consequences of exposure to death camps and the POW experience, as well as nonmilitary stressors, such as mass catastrophes—fires, earthquakes, or plane crashes (1). However, for reasons that remain obscure but that perhaps reflect the early links between military combat and the diagnosis of stress disorders, Gross Stress Reaction was somehow dropped from DSM-II. That manual was written when our country was not engaged in any major war. However, the scientific study of the consequences of stress continued. In fact, your editor began her early research career by studying the consequences of severe burn injuries in the pre-DSM-III era—identifying symptoms, risk factors for poor outcome, and the prevalence of severe psychiatric consequences (2–5).

DSM-III was crafted in the post-Vietnam era, a time when our country contained yet another wave of young men who had been exposed to the trauma of combat. VA and military psychiatrists had no official diagnosis to give them, as long as DSM-II was the official diagnostic manual. As a member of the DSM-III Task Force, I was assigned to this problem. An active group of advocates were lobbying for the inclusion of a diagnosis of "Post-Vietnam syndrome." The purpose and the concept were correct, but the name and the specificity were not. I pointed out the long history of the syndrome, as

well as the fact that it frequently occurred in traumatized civilians as well. A stress syndrome characterized by reliving, indicators of autonomic overarousal, and other such features was simply a final common pathway with many different sites of entry. We worked together to agree on diagnostic criteria, which were rooted in the extensive literature on stress disorders already available at that time, and christened our 100-year-old offspring Post-traumatic Stress Disorder. I wrote the entire text description of the syndrome, which was based on my experience caring for burn patients and the substantial literature available at the time. My burn patients had almost universally experienced this syndrome immediately after their injuries. So we designated an acute form of PTSD. However, many soldiers do not develop stress symptoms until they return home, since a stress reaction in the midst of combat is not adaptive, and so the impact of their traumatic experiences is delayed. Therefore, we also identified a delayed form.

The concept of PTSD took off like a rocket, and in ways that had not initially been anticipated. The DSM-III text struggled with many issues: how severe should the trauma be? What types of trauma could be considered causative? Does it make a difference if the trauma is inflicted by another human being, by an accident, or by a natural disaster? What impact does duration of the stressor have? What impact does premorbid psychiatric status have? And so on. PTSD is a complex concept. The DSM-III formulation emphasized that the stressor should be significant—outside the range of normal human experience. It assumed, but did not explicitly state, that there would be a temporally close juxtaposition between the stressor and the development of symptoms.

Many psychiatrists liked the DSM-III formulation and began to use the diagnosis widely. Its application broadened steadily. For example, it was used for victims of childhood sexual abuse who developed traumatic stress symptoms much later. Dissociation, a component of the original definition but not its core, received increasing emphasis. And the requirement that the stressor be outside the range of normal human experience was sometimes reinterpreted to include less severe stressors. In fact, that stringent requirement was dropped in DSM-III-R and DSM-IV, providing a much broader concept than was originally intended. (In my view, this broadening should be reconsidered. Giving the same diagnosis to death camp survivors and someone who has been in a motor vehicle accident diminishes the magnitude of the stressor and the significance of PTSD.) Acute PTSD, dropped from DSM-III-R, was fortunately added back in DSM-IV with a new name: Acute Stress Disorder.

This issue includes several articles on various forms of PTSD. The literature on this diagnosis is now vast. It goes far beyond the descriptive psychopathology upon which the original DSM-III definition was based. We now have a multitude of papers covering topics such as neural mechanisms as revealed in imaging studies, risk factors, prevalence, comorbidity, symptom patterns, and outcome. The study of PTSD has enriched our conceptualization of memory in both its conscious and unconscious forms. The task of summarizing all this literature—and producing a DSM-V description and definition—will be challenging. Not all the studies converge on the same conclusions.

Why?

A clue is provided by the articles in this issue. Although the final common pathway (in the psychological and physical/autonomic sense) is the same, there are many different kinds of stressors. As detailed by Verger et al., experiencing a terrorist bombing in a metro—a man-made and unanticipated disaster that produced concomitant physical injuries, facial deformities, and the psychological terror that was intended—is indeed something outside "the normal human range." A PTSD prevalence rate of 31% was observed approximately 2.6 years after the event. If anything, this seems surprisingly low, but the assessments were done via phone interview and could be an underestimate. A companion paper by Fullerton et al. examines both ASD and PTSD in disaster workers at the site of a plane crash. Their stressors are quite different. A plane crash is an accident, and therefore has a different impact than man-made malevolence. Disaster work-

ers have chosen their occupation with foreknowledge of its risks. To say this is not to diminish the enormous value of their work. But the psychological impact is different. And, not surprisingly, the prevalence of PTSD at a 13-month assessment was lower than in the terrorism victims: 16.7%. The studies examine different predictors of outcome and produce different results. These articles are but two examples of the many difficulties in conceptualizing the essence of PTSD and its consequences. A third article by O'Donnell et al. examines the thorny issue of comorbid depression. (The original concept of Gross Stress Reaction specified that it must occur in an otherwise normal individual—which was probably wrong, since stressors do not preferentially occur in normal individuals, and those with other disorders may have fewer adaptive resources remaining.)

As the psychiatrist who was also midwife at the birth of PTSD, I have followed its growth and maturation with great interest. Others have parented it, and generally well. It is of particular interest in the 21st century, when the entire world is filled with the spectre of terrorism—a stressor of great magnitude that can strike any time and anywhere. This is also a time when we again will have many young soldiers returning from yet another war: the treacherous combat experience in Iraq and Afghanistan. Unfortunately, the present world situation is likely to give us many more opportunities to study ASD and PTSD. For this I have regrets, but I am pleased that I helped create a diagnostic category and conceptual framework for this important syndrome, so that its causes and consequences can be examined both clinically and scientifically.

References

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