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Definition: Posttraumatic Stress Disorder

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Introduction

As far back as 490 BC, the Greek historian Herodotus described the psychological impact of exposure to traumatic events in his accounts of soldiers' reactions to the horrors of war. However, not until the nineteenth century would the sequelae associate with what today is called Posttraumatic Stress Disorder (PTSD) gain scientific attention. Beginning with British doctor John Eric Erichsen (1818-1896), "trauma syndrome" was identified in survivors of train accidents and attributed to organic causes. The German neurologist Hermann Oppenheim (1858-1919) renamed the syndrome "traumatic neurosis" and similarly identified organic changes in the brain as the origin of unexplainable reactions to horrifying and life-threatening events (Van Der Kolk, McFarlane and Weisaeth, 1996).

Not until the research and clinical work of psychiatrist Pierre Janet (1859-1947) would traumatic stress responses be rigorously described as symptoms of a psychological disorder. Janet viewed posttraumatic reactions as evidence of the failure to psychologically and physiologically integrate memories from a traumatic event with otherwise normal mental and physical functioning. He identified the primary symptoms of psychological trauma as the uncontrollable sense of reexperiencing a traumatic event, combined with defense reactions against such repeated recall (Ogden, Minton and Pain, 2006). Along with Janet, JM Charcot (1825-1893), Alfred Binet (1857-1911), Morton Price (1854-1929), Josef Breuer (1842-1925), Sigmund Freud (1856-1939), and Sándor Ferenczi (1873-1933) were some of the first to theorize the psychological impact of traumatic events (Leys, 2000).

Almost a hundred years passed before PTSD became an official psychiatric diagnosis. Mimicking the oscillation between absorption in memories of past trauma and their avoidance, recognition of the psychological impact of traumatic events has also fluctuated. Interest in the impact of traumatic events typically gained more attention during wartime when large numbers of veterans became overwhelmed by traumatic stress. During World War I, English physician Charles Samuel Myers (1873-1946) coined the term "shell-shock" to identify the psychological impact of battlefield experiences. However, when Myers discovered soldiers lacking combat produced the same symptoms, he asserted war-related neuroses were primarily emotional disturbances. Myers also observed similarities between war neuroses and hysteria, a diagnosis primarily given at the time to women with suppressed histories of sexual abuse. Both war neurosis and hysteria were typically seen as character flaws rather than as responses to life-threatening or horrifying experiences (Van Der Kolk, McFarlane and Weisaeth, 1996).

Interest in traumatic stress waned only to reemerge as a topic of interest following the Vietnam War. Initially, the connection between witnessing atrocities and the later development of a mental disorder was resisted and preference was given for organic explanations of the symptoms. After much struggle and petitioning, in 1980 Posttraumatic Stress Disorder became a formal mental disorder in the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Initially, PTSD applied primarily to responses to natural and man-made disasters. During the Second Wave of feminism in the 1970s, the symptoms of PTSD were extended to women with histories of sexual assault. Over time, PTSD has been expanded to include the effects of domestic violence, childhood abuse, medical illnesses, torture, and captivity (Herman, 1997).

Keywords

anxiety, dissociation, hysteria, nightmares, posttraumatic stress, shell-shock, trauma, war neurosis

Definition

The Diagnostic and Statistical Manual of Mental Disorders characterizes PTSD as an anxiety disorder. The decisive factors determining if a person has PTSD are: 1) exposure to a life-threatening event or serious injury (regardless if the threat was to oneself or others); and 2) feelings of horror or profound fear at the time of the event. The symptoms associated with PTSD fall into three clusters: 1) the persistent recall of the traumatic event, which can involve intrusive imagery, nightmares, a felt-sense that the trauma is recurring, and states of extreme distress in response to external or internal reminders of the trauma; 2) the persistent avoidance of reminders of the traumatic event, which occurs through psychological defenses such as dissociation, a limited affective range, and a foreshortened sense of future, as well as purposeful isolation; and 3) symptoms of increased arousal that impact the ability to sleep and concentrate, contribute to an exaggerated startle response, and are noted by the presence of irritability, angry outbursts, and rage. In children, recall of the trauma is witnessed through nightmares and in repetitive play around themes associated with the traumatic event.

Traditional Debates

One of the traditional debates surrounding PTSD concerns the origins of the traumatic stress response and whether it is more an organic or psychological disorder. This debate has continued since the nineteenth century when the impact of trauma first received scientific attention. When psychoanalysis was the dominant paradigm during the first half of the twentieth century, traumatic responses were often viewed as defense mechanisms against repressed unconscious wishes and impulses based more in fantasy than as reaction to events—a view made popular by Sigmund Freud (Van Der Kolk, MacFarlane, Weisaeth, 1996). Today, the biological aspects of trauma are thought to be universal and part of the body's natural response to threat. When threat is detected, the body's survival responses are activated (i.e., fight, flight, submit, or freeze), and the suppression of these defense responses are thought to lead to PTSD. Thus, PTSD is seen as an inhibition of an otherwise normal reaction to extreme threat (Ogden, Minton and Pain, 2006).

Despite the tendency to perceive PTSD as largely a biological response, the debate continues about how best to treat PTSD, with most of the argument addressing whether traditional talk therapy is preferred, or whether somatic-based psychotherapies and exposure therapies are better suited for traumatized persons. Psychopharmacology has shown to provide limited support, and some argue it impedes the body's natural capacity to work through the traumatic stress (Van Der Kolk, MacFarlane, Weisaeth, 1996).

Another traditional debate surrounding PTSD concerns its classification in the DSM as a response to a single, traumatic event. Given the often chronic nature of traumatic exposure, including childhood abuse, domestic violence, torture, and other traumas for which the trauma is continual and often unrelenting, Judith Herman, Bessel van der Kolk, and other trauma specialists have argued for a separate diagnosis of Complex PTSD to acknowledge the different sequelae and treatment needs of individuals who have endured chronic traumatization and were the victims of violence and oppression (Herman, 1997; Van Der Kolk, MacFarlane, Weisaeth, 1996).

Critical Debates

Whereas the biological response to trauma is seen as universal, the meanings attributed to traumatic events and how individuals cope with traumatic stress have been the subject of critical debates. Many arguments focus on how traumatic stress responses differ between individuals, as well as between genders, ethnicities, cultures, and societies. Studies have shown how reactions to trauma are affected by expectations about exposure to traumatic events, the treatments available, and sociocultural resources and norms for responding to traumatic events. These differences are also related to what types of events are perceived as traumatic (Marsella, Johnson, Watson and Gryczynski, 2008).

Critical debates also focus on powerlessness, rather than overwhelming feelings of fear, as the most damaging aspect of trauma, which the current definition of PTSD in the DSM ignores (Herman, 1997). Shifting the focus of PTSD to the experience of powerlessness has led to attributions of traumatic stress to victims of homophobia, sexism, racism, and other forms of oppression, including economic oppression. Conversely, the attribution of PTSD to non-Western populations led to accusations of colonization in which PTSD is viewed as pathologizing normal responses to an oppressive, violent, and dangerous world. Diagnosing PTSD to non-Western populations has also been described as a justification for appropriating Western norms to both the psychologies of other groups as well as reconstruction efforts that open areas to Western markets and globalization, particularly when responses to large-scale disasters incite relief efforts that lead to rebuilding societies and infrastructures according to Western models (Summerfield, 1999).

Some have argued for the removal of PTSD from the DSM on the grounds that exposure to the mental health system, especially psychiatry, perpetuates feelings of powerlessness when victims of violence and oppression are treated as if they suffer from a disorder that ignores the central role of power for their symptoms (Burstow, 2003). Others believe that all mental disorders are associated with some traumatic experience, particularly histories of childhood abuse and other

adverse childhood experiences, and the mental health system, including the DSM, should reorganize to address the central role of traumatic stress for all mental disorders (Ross, 2000).

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Online Resources

The Trauma Center (<http://www.traumacenter.org/>)