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ABSTRACT
The embellishment of a warrior biography has a long history but examples of veteran elaboration of traumatic experience have become increasingly apparent. Although legislative change in the UK has removed the penalties for fabrication and a progressive decline in the military footprint may have increased the likelihood of such false trauma narratives, a paradigm shift in explanations for mental illness underpins this phenomenon. The recognition of post-traumatic stress disorder (PTSD) in 1980, followed by studies to identify risk factors, led to a greater appreciation of psychological vulnerability. As a result, the use of shame to discourage acts formerly labelled as “cowardly” or “lacking in morale fibre” is no longer considered appropriate. Recent conflicts in Iraq and Afghanistan generated popular sympathy for service personnel, whilst media focus on PTSD has led the UK public to believe that most veterans have been traumatised by their tours of duty.

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Introduction
The status of the veteran in the UK is not static nor, indeed, is there agreement about how the term should be defined. Derived from the Latin “vetus” meaning old, a veteran was traditionally regarded as a regular soldier who had completed a lengthy period of service overseas during which he had experienced the dangers of combat. Charles Carrington having survived three “tours” of duty in a front-line trench at the Battle of the Somme wrote “we gave ourselves airs as veteran soldiers.” Associated with elderly males, the public were often supportive of such ex-servicemen as witnessed by the respect shown to Chelsea Pensioners. The esteem attached to the veteran in fiction was reflected by the character of Dr John H. Watson, who Arthur Conan Doyle portrayed as having been invalidated from India with enteric fever and a shoulder wound suffered in the Second Afghan War whilst serving with the Army Medical Department. However, two world wars broadened the membership of the veteran category extending it to volunteers and conscripts with shorter periods of military service, though often requiring no less resolve. The dramatic increase in the ex-service population removed some of the mystique attached to the warrior. Furthermore, the mobilisation of the UK
population during World War Two and the consequent sharing of suffering and loss by civilians and the military undermined support for veteran special status. During the post-1945 period, for example, ex-servicemen reported prejudice from civilians who believed that they threatened their job prospects.

With the end of National Service in 1960, the UK returned to an earlier model of military service: a small, professional force composed of volunteers deployed overseas albeit in diverse roles. Popular interest in the UK armed forces remained muted throughout the Troubles in Northern Ireland and by the late 1980s some military charities were considering merger to compensate for dwindling revenues. However, the deployment of 45,000 UK troops to Iraq in 2003 brought the armed forces to the fore. In the context of an unpopular war and claims that the government had failed to protect its troops by the provision of body armour and appropriately armoured vehicles, attention increasingly focused on the demands made of the individual soldier. A campaign by military charities and the UK media suggested that successive governments neglected service personnel once they had been discharged, whilst arguing that the unique nature of their duties granted them a right to special status in terms of commemoration and state benefits. In May 2004, the issue of a veteran lapel badge marked a change in emphasis. On 27 June 2006, the first official “Veterans’ Day” (chosen to coincide with the first investiture of the Victoria Cross in 1857) was held to acknowledge the contribution of ex-servicemen and women.

The Armed Forces Compensation Scheme of April 2005 introduced an inclusive definition for the UK veteran: a single day of paid service in regular or reserve forces. Using this low-bar criterion, the Royal British estimated that there are 4.8 million ex-service personnel in Britain and Northern Ireland (7.5% of the UK population of 64.1 million in 2014), a figure predicted to decline to 3.1 million by 2020. However, the UK definition stood in marked contrast to other nations. To receive benefits from the US Department of Veterans Affairs (VA) requires at least 90 days of active duty service, with at least one day during a VA recognised wartime period, though the 90-day active service requirement does not apply to veterans discharged from the military due to a service-connected disability. In Australia, under the Veterans’ Entitlements Act of 1986, a veteran is defined as a person who has rendered “eligible war service” and who has “engaged in warlike operations against hostile forces outside Australia.” Despite the low bar set for veteran qualification in Britain, a survey conducted by Lord Ashcroft in 2012 found that members of the UK armed forces were rated highly (at 7.7 on a scale of 10) significantly above staff in the National Health Service (NHS) (6.6), the British Broadcasting Corporation (BBC) (6.4) or the police (6.2), largely because they were considered “brave” and “courageous.”

Although a number of studies have explored the fabrication of service experience by veterans, there has been less research into the motivation for an illness narrative. This article focuses on the case of UK veterans to explore the context behind exaggerated trauma narratives. An extensive literature review was conducted by hand searching leading medical and psychological journals relating to World Wars One and Two, whilst for more recent publications, Medline, PsychLit and Web of Knowledge were searched using combinations of keywords, which included veteran, fabrication, military footprint and psychological disorder. The article discusses whether recent changes in legislation (the Armed Forces Act of 2006) and cultural shifts have increased the likelihood of such cases and explores the implications for UK policy.
Elaboration of traumatic experience

In December 2013, Jan Trethowan was tried at Plymouth Magistrates Court for driving whilst disqualified and without car insurance. In mitigation, his lawyer argued that he suffered from post-traumatic stress disorder (PTSD), a consequence of four tours to Iraq and Afghanistan with the Royal Marines and subsequent service in the French Foreign Legion. Confirmation of Trethowan’s service was sought and, though it was discovered he had served with the Devon and Dorset Regiment between 2003 and 2005 and a year with the Royal Artillery leaving the forces in 2007, much of his story was false.15 With the report of a number of similar cases, the question was asked whether the elaboration of psychological trauma is a contemporary phenomenon.16

Evidence from earlier conflicts suggests that such illness narratives have a long history. During World War One, the Ministry of Pensions was concerned that servicemen discharged with a diagnosis of shell shock could exaggerate their symptoms either to obtain a higher award or to extend payment beyond a time when the disorder had remitted. Established in December 1916 with a schedule of compensation for grades of injury and disablement, the UK war pension system included shell shock and other psychosomatic illnesses within its remit.17 To guard against elaborated claims, the Ministry routinely verified applicants’ service records and medical files, requesting a specialist opinion in the case of disputed claims.18 In the six years following the Workmen’s Compensation Act of 1906, the sums paid in accident compensation rose by 63.5% despite the fact that the number of people in employment remained the same.19 So concerned was the Ministry that it had appointed John Collie, a pre-war expert in the assessment of compensation for industrial injury as its chief medical officer. Collie also chaired the committee that considered claims for shell shock and other psychosomatic illnesses. In 1917, he revised his textbook, *Malingering and Feigned Sickness with Notes on the Workmen’s Compensation Act, 1906*, adding a chapter on the military in which he observed that “the thin line which divides genuine functional [without organic basis] nerve disease and shamming is exceedingly difficult to define.”20 Collie believed that psychological trauma was more readily fabricated than its physical counterpart. Whilst the extent to which trauma was fabricated remains unknown, the scale of psychological injury was significant with 65,000 pensions for neurasthenia and shell shock in payment in February 1921.21

During World War Two, military psychiatrists faced the accusation that they increased opportunities for malingering (the deliberate falsification of symptoms to evade duties) because they reclassified behaviour traditionally considered an expression of low morale or poor discipline as symptomatic of psychological disorder.22 To address these accusations, Lt Colonel Roy Grinker and Captain J.P. Spiegel, two psychoanalytically-trained doctors, deployed to treat US forces in Tunisia argued that “war neuroses cannot be malingered, even superficially.”23 They rejected the proposition that most symptoms were simulated and reasoned that the so-called “secondary gain” (in this case release from combat duty) did not outweigh the long-term “suffering of the war neurotic.” Furthermore, a study conducted for the War Office in August 1941 by Lt Colonels Tom Main and A.T.M. Wilson of 300 British servicemen with persistent misconduct showed that 50% suffered from learning disabilities.24 When the creation of a special section of the Pioneer Corps with educational and welfare support for such soldiers reduced sickness
and disciplinary rates, military psychiatrists could argue that their interventions had outcomes that reduced malingering.25

The case of Vernon Scannell indicated that by the end of the war military psychiatrists were attuned to the deceptions of veterans. In 1945, before his demobilisation papers had arrived, Scannell deserted from the British Army. Arrested two years later and brought before a military court, his defending officer cited his service as an infantry soldier in North Africa and Normandy, arguing that his aberrant behaviour was the consequence of shattered nerves. Finding himself referred to an army psychiatrist, Scannell recalled that he “had flirted with the idea of parading alarming symptoms of mental disorder but common sense warned me that I would be unlikely to deceive a man who had probably seen through the pretences of scores of more skilled malingers.”26 In the event, he was referred to the army’s psychiatric unit at Northfield. There, after a brief admission, another military psychiatrist discharged Scannell on the grounds that he could find no sign of formal psychiatric illness.27

An opportunity to study the scale of malingering arose in autumn 1943 when the repatriation of British prisoners-of-war by the Germans allowed researchers in the Royal Army Medical Corps to investigate the psychological effects of captivity.28 Most of those in the study group (numbering 1154) were medical orderlies who had been imprisoned for at least three years. To assess the impact of imprisonment, they were compared with a control population of RAMC recruits who had not served overseas. The repatriates were assessed as suffering from low morale and 60% were judged to exhibit “minor psychological disturbances.” However, their rate of psychosomatic illness (4.8%) was not significantly higher than that of the control population (2.8%), though they were also significantly more likely to commit minor military offences (9.1% compared with 0.2%).29 This data suggested that psychosomatic illness and its effect on behaviour, though at a low level, was likely to present a significant problem for the health service and employers when the vast army of conscripts was demobilised. In May 1945, the War Office set up 20 Civil Resettlement Units for returning POWs designed to provide welfare support during transition. They offered re-education, training and “re-socialisation” programmes under light military discipline with input from a Ministry of Labour vocational officer and, when needed, psychiatric social workers.30 Attendance was voluntary for Army personnel and 53,000 veterans (1.4% of the 3.8 million who served in the British Army during the conflict) attended the six-week residential courses.31 This evidence, together with the fact that most veterans readily found work on discharge from the forces, led the War Office to believe that psychological disorder and its elaboration were at a low levels.

Elaboration for financial gain is more likely to occur during economic recession when opportunities for well-paid employment are limited. The demobilisation of British forces after World War Two occurred at an opportune time. An upswing in the trade cycle and the colossal demand for goods and services, the immediate post-1945 period witnessed full employment. In contrast to the 1930s, when UK unemployment was never less than 9.3% and rose to a peak of 22.1%, the six years from 1945 saw those out of work remain below 3.1% and fall as low as 1.3%.32 Under the 1944 Reinstatement of Civil Employment Act, companies were required to re-engage former members of staff, who had served in the armed forces, for at least 6–12 months, depending on the length of their pre-war employment record.33 By contrast, the recent spate of cases reported in the UK media
corresponded with a sustained recession in the British economy (2008–2013), the deepest downturn of the post-1945 period.

**Retreat of cowardice**

The 50 years following the end of World War Two saw psychology take root in UK culture not only as an academic discipline and in myriad forms of therapy but also as a popular way of explaining behaviour. These new perspectives influenced traditional beliefs about the appropriateness and value of using the term cowardice to shame individuals. During the nineteenth and early twentieth centuries, it was a powerful construct designed to regulate behaviour of soldiers on the battlefield. Those accused of cowardly actions were not only vilified, they also ran the risk of being executed. Chris Walsh has argued that the retreat of the term in popular usage (falling from an incidence of 5.5 per million words in the 1830s to only 1.4 per million in the 2000s) reflected the advance of psychological medicine into areas formerly categorised as issues of morality and the law.

Questionable military behaviour that was traditionally labelled “cowardice” has been reframed in terms of vulnerability. Research conducted into the psychological demands of combat during and immediately after World War Two provided evidence about how long individuals could be expected to cope when exposed to extreme threat or stress. Studies of Royal Air Force (RAF) aircrew in 1943–1944 by C.P. Symonds and Denis Williams, two neuropsychiatrists, were used to frame guidelines about the number of sorties that pilots were expected to fly in particular commands. RAF clinicians used this data to lobby against the use of the term “lack of morale fibre,” a euphemism for cowardice introduced in April 1940 to shame airmen who refused to fly without a demonstrable mental or physical illness. As psychological constructs were increasingly used to explain aberrant behaviour, the space occupied by cowardice was eroded, undermining its ethical weight. A major survey of US armed forces published in 1949 by Samuel Stouffer and his team found that between 67% and 77% of junior officers in infantry units agreed that “men who crack up in action ... blow their top, go haywire” should be “treated as sick men.” Fewer than 6% thought that such cases “should be treated as cowards and punished.” Similar scores and responses were given by enlisted men (private soldiers and non-commissioned officers) from combat divisions. When set against executions for cowardice during World War One, this evidence suggested not only a growing familiarity with psychological ideas but also a greater tolerance of fear reactions.

The formal recognition of PTSD by the American Psychiatric Association in 1980 represented a fundamental change in the causal explanation attached to psychological breakdown. During both World Wars, the soldier himself had been held responsible for his inability to function. To explain why only a minority suffered from enduring symptoms after a terrifying or stressful event, combat itself was interpreted as a trigger. Family history of mental illness, pre-existing psychological disorder or childhood conflict were factors highlighted to explain why some became psychiatric casualties and others did not. By assigning primacy to the traumatic event and relegating personality factors to a secondary role, PTSD reversed causality. Subsequent research into the incidence of PTSD in military populations generated a range of risk factors, which have been categorised as psychological vulnerability. These include temperament, family history, education and pre-enlistment experience. Thus, the adoption of PTSD as a recognised illness
was part of a process that replaced traditional notions of character weakness by scientifically validated measures of risk for psychological disorder. As a consequence of this re-evaluation, researchers have conducted retrospective studies of combat veterans of World War Two only to discover significant rates of PTSD. However, such studies encounter methodological problems such as recall bias, issues of verification and the fact that, in retirement, elderly veterans often take strength from recall of wartime experiences.

The “culture of trauma,” the historian Ben Shephard argued, weakens a core defence against cowardice: if the fear of being judged cowardly is reduced then there is less pressure to resist the impulse to flee the battlefield. However, a contemporary study of UK armed forces deployed to Afghanistan suggested that stigma of mental illness has taken on the role formerly performed by the construct of cowardice in encouraging stoicism and toughness. Servicemen were found to be less tolerant of psychological disorder in theatre compared with home postings.

Contemporary focus on emotion, combined with growing acceptance of PTSD as a legitimate response to a terrifying event, has led to a re-evaluation of the deserter. Charles Carrington, a decorated infantry officer, recalled of his World War One service, “it was one thing to make jokes about swinging the lead (shirking duty) … and quite another to avoid a dangerous task which someone else must do if you did not.” If soldier who left his post without permission was shown to have been suffering from a psychological disorder, then his desertion could be reframed not as cowardice but the final act of an exhausted warrior. “The astounding fact,” concluded Glass, “is not that so many men deserted but that the deserters were so few.” The success of psychological vulnerability in supplanting cowardice was demonstrated in August 2006 when Private Harry Farr, who had been executed for desertion in October 1916, was pardoned by the UK government. The judgement was justified because a hospital admission for shell shock suggested that Farr’s behaviour could be explained in terms of continuing mental illness. Commentators and the media concluded that Farr had suffered from an illness akin to PTSD. In fact, the official pardon reflected rather than led popular opinion as Farr and the other 305 UK servicemen executed in World War One had been commemorated in the Shot at Dawn Memorial opened in June 2001 at the National Memorial Arboretum.

Whilst motives for elaborating traumatic experience can be readily identified, it is less obvious why some veterans falsely claim to have committed atrocities against civilians. In 1988, Columbia Broadcasting System (CBS) television broadcast a documentary entitled The Wall Within, which featured five Vietnam veterans who had all been diagnosed with PTSD. Three of the five stated on camera that they had committed violent acts against innocent civilians. Several years later B.G. Burkett, a Vietnam veteran, obtained copies of their military records and discovered that these events were fictional and significantly that only one of the five had taken part in combat. It appears, therefore, that the false atrocity was cited to support a claim of combat-induced PTSD. In May 2000, Edward Daily, a US veteran of the Korean War, made a much publicised return to the village of No Gun Ri, where he sought forgiveness from the local people for his participation in a massacre of civilians by a company of the Seventh Cavalry. However, research into military records revealed that Daily had not taken part in the shooting, nor indeed had he been in the area. Indeed, at the time of the
atrocity, he was a mechanic in the 27 Ordnance Maintenance Company. During the 1980s, Daily attended reunions of the Seventh Cavalry and in 1990 published a history of the unit’s operations in Korea, so that his elaboration served, in part, to authenticate membership of an elite unit. In extreme cases, a veteran may cite an atrocity narrative and the severe trauma that it entailed to explain personality change. This appears to be a post-PTSD phenomenon. Whilst there are several cases of individuals falsely claiming to have been Holocaust survivors, there are no documented cases of veterans purporting to have been perpetrators of Nazi war crimes.

Fabrication of traumatic exposure

Formal study of traumatic elaboration was facilitated by US Freedom of Information legislation, which allowed Burkett and Glenna Whitely, an investigative journalist, to obtain the service records of individual Vietnam veterans. Although they hypothesised that “as many as three-quarters of those receiving PTSD compensation are pretenders,” a proposal for clinical study supported by verifiable data was shelved. Subsequently, Christopher Freuh reviewed the records of 100 US Vietnam veterans attending a VA treatment programme for combat-related PTSD. Documented evidence of combat exposure was found in only 41 cases, whilst three ex-servicemen had not been deployed to Vietnam and two subjects had never served in the US armed forces. In the UK, Baggaley found that 13% of ex-servicemen referred to a military psychiatric centre for the treatment of combat-related PTSD had falsified their traumatic exposure. Further study by Palmer of 150 UK veterans referred for the assessment of medically unexplained symptoms at a Ministry of Defence clinic found that 10% had fabricated or significantly exaggerated the account of their traumatic exposure when accounts were verified against their medical records and unit war diaries.

The willingness to falsify psychological trauma by a sub-group of veterans stands in contrast to the stigma exhibited by most UK and US ex-service personnel who equate the disclosure of mental illness with a form of weakness. A study of a representative sample of 496 UK veterans showed that only half of those reporting mental health problems during service had sought help, a proportion that increased only slightly when individuals left the armed forces. Their unwillingness to disclose related, in part, to self-stigma and the belief that the veteran should be able to overcome such issues unaided. Military culture, which emphasises resilience and toughness, may inhibit service personnel from contacting health professionals to address psychological trauma, many preferring to contact informal sources of help such as chaplains and colleagues. Why some veterans are willing to present false or exaggerated mental health problems when the majority of their former colleagues prefer to conceal their psychological symptoms remains an interesting question. Some evidence suggests that elaborators may have felt marginalised when serving or feel rejected as a result of demobilisation. A study of 153 UK veterans in receipt of a war pension for PTSD or a physical disability by Chris Brewin and colleagues found that psychological illness was associated not with negative views of the self but a growing sense of alienation from civilian life. Elaboration for some may be an attempt to communicate the sense of isolation and loss of self-worth expressed by this group of war pensioners.
Legislative change

Recent legislative change in the UK removed penalties for elaboration. Section 197 of the 1955 Army Act stated that any person, who “uses or wears any decoration, badge, wound stripe or emblem … as to be calculated to deceive” or “falsely represents himself to be a person who is or has been entitled to use or wear such decoration, badge, stripe or emblem … shall be guilty of an offence” and liable to a fine or imprisonment. However, the Armed Forces Act of 2006, which replaced this legislation, contained no legal sanctions against military deception. By contrast, the US government introduced the Stolen Valor Act in December 2006, which made it a federal crime to fraudulently claim to be a recipient of certain military decorations or medals in order to obtain money, property, or other tangible benefit. Although revoked in June 2012 as an unconstitutional abridgement of the freedom of speech, a second Stolen Valor Act was signed into law by President Barak Obama on 3 June 2013 which reintroduced penalties for military falsification. In the UK, a recent spate of ex-servicemen falsifying traumatic exposures has led to calls for new legislation to restore the penalties of the 1955 Army Act.

Reduction of the military footprint

As the UK military footprint has been eroded by the end of National Service, progressive defence cuts and a decline in the number of opinion formers (not least in government) with military experience, so public understanding of veteran issues has also diminished. By 1945, conscription had raised UK armed forces to 4.65 million, whilst the introduction of National Service maintained numbers in uniform at around half a million during the 1950s. This stands in contrast to the 146,980 comprising UK regular forces in October 2014. Knowledge of military culture was widespread during the 1950s and 1960s, whilst many civilians who had served in the emergency services or suffered the stresses of air-raids had direct experience of combat. With a significant proportion of doctors, nurses and other health professionals having served in the armed forces or having treated civilian casualties, false warrior narratives were more readily identified than today.

Although understanding of UK veterans and their needs by the public and employers is inconsistent, popular support for the individual soldier or veteran is at a high level. For example, Help for Heroes, the military charity set up in October 2007, raised over £200 million by September 2012 from donations and fund-raising activities. With a desire to help, civilians have become increasingly reliant on the media and military charities for information about ex-service personnel. Yet these sources are not without bias or special interest. Both the press and the third sector are attracted to narratives of distress as they engage popular interest and sympathy. By 2008, when the House of Commons Defence Committee investigated the recruitment and retention of UK armed forces, the belief that the conflict in Iraq had generated a significant number of traumatised veterans had taken root. The Committee concluded that there had been “a failure in the part of the Ministry of Defence adequately to deal with the forthcoming PTSD bow wave.” In April 2009, Commodore Toby Elliott, chief executive of the military, mental-health charity Combat Stress, was quoted in the Sunday Times as reporting that the number of troops with psychological disorders was “beginning to mount up” and that this represented...
“the bow wave of a much greater problem.” That the British public had been persuaded by the media, charities and politicians was confirmed by a survey conducted in 2012 by Lord Ashcroft, which found that:

more than nine out of ten of the public thought it was common or very common for personnel leaving the Forces to have some kind of physical, emotional or mental health problem (though personnel themselves did not seem to share this view).

This popular belief stands in sharp contrast to a recent study of UK armed forces which found that rates of probable PTSD were 4% for the army as a whole and 7% for front-line units, not significantly elevated from the 3% recorded for the entire British population.

**Conclusion**

The place of the veteran in UK culture continues to evolve with ambivalence expressed by both the public and ex-service personnel themselves. A study of a random sample of 200 former UK regulars and reservists conducted in 2012 found that only 52% described themselves as a “veteran” despite meeting the Ministry of Defence criterion for the term. This suggests that service personnel themselves continue to observe the culturally-embedded meaning of the term as an elderly ex-soldier with campaign experience. Indeed, of the 200 in the sample, 41 (21%) had served for less than 6 years and 94 (47%) for less than 12 years, whilst 59 (29.5%) were under 30 at the time of the interview, only 44 (22%) being aged 45 or older. The withdrawal of UK forces from Afghanistan and further reductions to government expenditure (which impacts not only the numbers in the regular forces but also on a willingness to deploy troops in operations overseas) are likely to take the spotlight away from veteran issues. Before World War One and the recruitment of a vast citizen army, the armed forces in Britain were held with pride but at the margins of society, a perception reinforced by deployment to distant territories on imperial duties. Although respectful of their army and navy, the British people felt no great responsibility for their ex-service personnel. Should the UK return to this traditional position, the incidence of psychological elaboration may fall because of an increasingly unreceptive audience.

Elaboration of trauma in a military context offends more than in civilian life because the deception draws on the status of the heroic warrior. Extreme courage commonly involves death (295 Victoria Crosses were posthumous) and the fabrication is judged disrespectful to the memory of servicemen and women who have experienced genuine trauma. As a result, discovery of a falsehood often invokes outrage rather than an attempt at understanding. Whilst penalties for such deceptions are indicated, they should not impede an attempt to discover why some veterans feel compelled to invent narratives of distress.

**Notes**

4. A. Wyatt, Development of the Veterans Initiative by the Ministry of Defence, Case Study (Sunningdale Park: The International Comparisons in Policy Making Team, the Civil Service College, 2002), 10.


25. Ahrenfeldt, op. cit., 86.


27. Ibid., 59–60.


31. TNA, LAB12/352, Minutes of a conference on Civil Resettlement, October 5, 1945, 2.


44. Nigel C. Hunt, Memory, War and Trauma (Cambridge: Cambridge University Press, 2010), 40.


54. Binjamin Wilkomirski, for example, claimed to have survived internment in Majdanek and Auschwitz but was discovered to have lived the entire war in Switzerland, Fragments, Memories of a Childhood 1939–1948 (London: Picador, 1996). Doubt has also been cast on the claim of Denis Avey, a British prisoner-of-war held near Monowitz, as to whether he exchanged places with a Jewish inmate of Auschwitz on two occasions. Inconsistences in his narrative have been explained by the effect of post-traumatic stress disorder. Denis Avey, The Man who broke into Auschwitz (London: Hodder and Stoughton, 2011).

55. Burkett and Whitley, op. cit., 279.


63. Army Act 1955 c. 18 (Regnal 3 & 4 Elizabeth 2).

64. Armed Forces Act 2006 (c. 52).


**Disclosure statement**

No potential conflict of interest was reported by the authors.