Psychological trauma: a historical perspective

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Paradigm change

During the 1970s a paradigm shift occurred in the way that psychological trauma was conceived and managed. Until then, it was argued that individuals without a family history of mental illness or other evidence of predisposition, if exposed to a traumatic event, might develop acute psychological distress, but would then go on to recover naturally with no long-term effects, rather like a self-healing wound. The discovery of a so-called 'delayed stress syndrome' during the Vietnam War seemed to show that healthy soldiers subjected to stress could suffer chronic, adverse effects that were not apparent at the time of their exposure. The terrifying event, until then regarded merely as a trigger, assumed a crucial importance in the genesis and description of psychiatric breakdown.

This new concept of psychological trauma also saw the retreat into obscurity of 'secondary gain', the attention and rewards that a patient received as a consequence of suffering from a recognized disorder. Before the 1970s anyone who broke down and suffered long-term effects was considered constitutionally vulnerable or the product of a degenerate family; in either case, responsibility lay with the individual. Not everything, however, was attributed to pre-exposure predisposition – since it was also considered that 'secondary gain', which was often but not exclusively financial, could inhibit the process of recovery. After the admission of post-traumatic stress disorder (PTSD) to DSM-III in 1980,[1] causation was attached to the event itself and individual sufferers were largely absolved from blame or responsibility. The novel diagnosis reflected a general cultural shift from the group towards the subject. Psychological casualties in both World Wars were, in part, considered a failure of group cohesiveness and morale. The vulnerable, it was argued, could be protected by training, comradeship and unity of purpose. Breakdown ultimately reflected on organization and leadership. The acceptance of PTSD by the American Psychiatric Association was in part a response to the anti-Vietnam War movement, which portrayed the veteran as a victim of an 'insane' and unpopular war, but was also a product of a society that regarded the needs of the individual as paramount, in which rights triumphed over duties.

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The First World War and psychological trauma

During the First World War the conscription of a mass civilian army, which in turn was subjected to the emotional pressures of trench warfare, led to an epidemic of post-trauma illness, termed 'shell shock'. At first an organic explanation was proposed: a microscopic cerebral haemorrhage caused by either the concussive or the toxic effects of an exploding shell. When it became clear that many servicemen with the symptoms of shell shock had not been close to an explosion and some not even exposed to combat, other explanations were considered. The intense stress of battle, or its immediate prospect, were identified as causal factors. W H R Rivers, the medically trained anthropologist who treated soldiers at Craiglockhart, believed that the disorder resulted from a failure of repression. Regular soldiers, he argued, had far greater time to build up an effective mechanism to control their fear and to master the inevi conflict between duty and self-preservation. Conscripts, who had not been able to establish these protective defences, succumbed to the pressures of the battlefield more readily. These ideas led post-war military planners to believe that the problem of war-related psychological injury was largely preventable. The Southborough Committee, set up in 1920 to investigate the nature of shell shock, concluded that well-led, highly trained units with high morale would be virtually immune from post-trauma illness.

While the term 'shell shock' entered the language, particularly through the writings of Graves, Sassoon and Owen, and where it has remained ever since (in the novels, for example, of Pat Barker), paradoxically its acceptance in both military and medical circles declined. By 1916 the army medical services had attempted to substitute the terms 'Not Yet Diagnosed, Nervous' (NYDN) and neurasthenia, and the following year the term 'shell shock' was officially banned, although it continued to be widely employed by Royal Army Medical Corps (RAMC) doctors and their patients. However, the post-war return to a small, regular army combined with a reluctance to engage in any serious conflict in Europe led to reduced use of the label, though concerns continued to be expressed about the complex boundaries between cowardice and psychiatric injury.

During the First World War serious manpower shortages led to a concerted drive to find an effective treatment for post-trauma illness (Table 1). Many contemporaries believed that 'forward psychiatry' – the so-called 'PIE' method – was the solution. It relied on three principles: proximity to battle, immediacy of treatment and expectation of recovery. In essence, soldiers were referred to specialist units located about 20 miles from the front, where they were fed, rested and put on a programme of graduated exercise

Some varieties of post-traumatic illness

Accident neurosis	Post-traumatic stress syndrome
Accident victim syndrome	Post-Vietnam syndrome
Battleshock	Profit neurosis
Combat fatigue	Railway spine
Combat stress neurosis	Shell shock
Compensationitis	Soldier's heart
Da Costa's syndrome	Traumatic neurasthenia
Erichsen's disease	Vertebral neurosis
Litigation neurosis	War neurosis
Nostalgia	Whiplash neurosis

Source: O'Brien, 1998.[2]

Table 1

for 2 to 6 weeks. At the time, clinicians claimed that at least 80% of admissions were returned to combat units, though recent research has questioned the accuracy of these outcomes.[3] 'PIE' has remained the standard intervention for combat stress reaction and was employed in the Korean War, the Vietnam War, the Lebanon and recent Gulf conflicts.

The Second World War and psychological trauma

In an effort to prevent the epidemic of shell shock seen in 1914–18, both the civil and military authorities outlawed the term in 1939 and announced that no war pensions would be awarded for psychiatric war injuries – the so called 'Horder' committee. Henceforth, soldiers traumatized by the stress of combat were to be diagnosed as suffering from 'exhaustion' and retained within the forces (Table 2). The term was chosen to imply that this was not a serious medical disorder but a condition that would recover naturally with rest and respite. Abreaction and the ventilation of emotion were not generally considered effective treatments. The control of fear and restoration of physical well-being were emphasized.

War syndromes characterized by unexplained medical symptoms

Pre-1914
Soldier's heart, irritable heart, palpitation, Da Costa's syndrome, disordered action of the heart, nostalgia, wind contusion

First World War (1914–18)
Shell shock, effort syndrome, neurocirculatory asthenia, war neurosis, gas hysteria, neurasthenia

Second World War (1939–45)
Effort syndrome, non-ulcer dyspepsia, psychoneurosis, battle exhaustion

Vietnam War (1965–74)
Effects of Agent Orange

Gulf War (1991)
Desert Storm syndrome, Gulf War syndrome, Gulf-related illness

Source: Jones and Wessely, 2005.[4]

Table 2

The emergence of psychiatric casualties after Dunkirk, among seasoned troops in the Western Desert and, later, the modest performance of units in Normandy that had proved highly effective in North Africa and Italy, demonstrated that post-trauma illness was not entirely preventable. Neither the public nor parliament was at ease with the ban on psychiatric discharges or pensions. It was gradually accepted that even elite soldiers exposed to intense or protracted stress could cease to function – 'every man has his breaking point'. Furthermore, statistics recorded by doctors for internal assessment showed forward units had returned only 20–30% of troops to combat units, though around 70% were retained in the forces in base or non-combatant roles. Treatment was not as effective as clinicians in the First World War had claimed.

PTSD defined

In the aftermath of the Second World War, US military psychiatrists undertook a number of retrospective analyses to discover how troops performed in battle and to assess the incidence of psychiatric casualties. In the light of this work, the US Army deployed specialist psychiatric teams during the Korean War. DSM-I, published during this conflict in 1952, contained the new category 'gross stress reaction', though no operational definition was provided.[5] It described the extreme behavioural responses of normal individuals to exceptional stressors such as war or natural catastrophes. Published in 1968 while the Vietnam War was in progress, DSM-II introduced the term 'transient situational disturbance'.[6] This included all acute reactions (even brief psychotic episodes) to stressful exposures. Central, however, to both the DSM-I and DSM-II formulations was the concept that these reactions would be short-lived.

Psychiatric reactions arising *de novo* in the context of combat were therefore expected to be brief and likely to resolve with a period of rest and recuperation. If symptoms or an inability to function endured, then it was argued that the true causes lay in earlier life, with the stress of battle acting only as a trigger. Although this interpretation was not challenged in either the First or Second World Wars, widespread public sympathy for men who broke down in battle did lead to large numbers of veterans being awarded war pensions for psychological disorders. 'Shell shock' was the first official acknowledgement of war-related psychiatric injury, as distinct from major mental illness.

Codified in DSM-III (1980), PTSD was originally termed 'Post-Vietnam syndrome' or 'delayed-stress syndrome',[1] having first been identified in veterans who had returned to the United States (Table 3). The treatment of acute combat fatigue (today termed 'combat stress reaction') had apparently been well managed by military psychiatrists attached to combat divisions. War-related psychiatric injury rates in Vietnam were low. However, some servicemen who had returned to civilian life presented with what appeared to be a range of delayed symptoms. Mental-health professionals who were politically opposed to the Vietnam War took up their cases. Charles R Figley, himself a Vietnam veteran and anti-war protestor, completed a doctorate on PTSD as part of his aim to demonstrate that 'the toll of war went far beyond the

Immediate and delayed disorders of trauma

Immediate

- Shell shock
- Battleshock
- Battle exhaustion
- Combat fatigue
- Combat stress reaction
- Acute stress reaction (ICD–10)
- Acute stress disorder (DSM-IV)

Delayed or chronic

- Neurasthenia
- War neuroses
- PTSD

Source: Jones, 2006.[7]

Table 3

battlefield',[8] and it is fair to say that he was already looking for what he would later find. Robert J Lifton, a prominent anti-war campaigner, was a key member of the sub-commission for reactive disorders that proposed the formal recognition of PTSD by the American Psychiatric Association, and was tasked by Nancy Andreasen to draw up what would become the definition of PTSD. In part, validation of the disorder's existence was a further way of undermining the US Government's pursuit of the war. If it could be shown that the conflict caused long-term and widespread psychological injury to US servicemen, then this was further reason to call the campaign to a close. Hence, along with '*Rentenkampfneurosen*' (pension struggle neurosis defined in pre-1914 Germany), PTSD was one of the few politically driven psychiatric diagnoses.

PTSD entered the psychiatric canon obliquely – not as a result of careful epidemiological or nosological research but more as a result of politically motivated lobbying.[9] Later observers have located its origins less in the jungles of Vietnam and more in the sociopolitical climate of America. Atrocities such as My Lai were given unprecedented publicity by a television media able to provide graphic pictures in the homes of most families. The intense and critical attention given to the War was quite novel, contrasting with the careful censorship employed during the Second World War to maintain morale amongst civilians. As a result, veterans, apparently subjected to stresses never felt by returning servicemen from other wars, were said to have become profoundly alienated. To the anti-war campaigners, they were a special case. A further factor driving the acceptance of a new psychiatric disorder was the enormous financial commitment made by the Veterans Administration (VA) in the treatment of PTSD, an investment that did not and has not led to any conspicuous therapeutic success, at least as far as Vietnam veterans are concerned.

PTSD: from Vietnam to the present

Since its formal recognition in 1980, PTSD has become a high-profile psychiatric disorder. The stressor criteria for PTSD have undergone progressive relaxation from the initial formulation of a life-threatening event ('existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone')[1] to the current requirement that the individual should have 'experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others'.[10] A change in societal values from groups to individuals, an increase in concern for the problems of victims and a media voracious for human-interest stories have all added to the popular acceptance of PTSD.

PTSD and history

A recent retrospective study of randomly selected samples of UK ex-servicemen of the Boer War, First and Second World Wars and the Gulf conflict showed that the incidence of flashbacks (a key PTSD symptom) was not uniform across all campaigns. Nine percent of Gulf veterans reported flashbacks, while only 0.5% of a sample of 640 First World War veterans and 1.4% of a sample of 367 Second World War veterans described the symptom.[11] None of the 400 Boer War servicemen in the investigation appeared to have experienced flashbacks. If PTSD were a universal response to exceptionally traumatic situations, then arguably such dramatic differences in the incidence of flashbacks would not have arisen. Nevertheless, it remains possible that reporting biases account for some of the differences between wars.

PTSD and culture

There is growing empirical support for Young's seminal interpretation of PTSD as a contemporary culture-bound syndrome.[12] Although symptom clusters representative of the diagnosis can be found in the past, epidemiological research suggests that their incidence was significantly lower than today. Evidence from earlier conflicts suggests that trauma tended to be somatized. During the First World War, for example, servicemen exposed to the intense or sustained stress of battle were often diagnosed as suffering from disordered action of the heart (characterized by rapid or irregular heartbeat, shortness of breath and chest pain) or from shell shock, typified by fatigue, contractures, tics, tremor and paresis. Framed against an epidemic of peptic ulcer, post-combat disorders in the Second World War were often expressed and explained in gastrointestinal terms.

Given the evolving nature of health fears and the creation of new risks by advances in technology, the psychopathology of trauma is unlikely to be static and culture appears to exert an influence on the expression of distressing memories. The concept of a 'universal trauma reaction', by which terrifying experiences are permanently and accurately preserved by being encoded in the brain in the manner of skills, habit and reflex reactions, appears flawed. It seems that PTSD is one further phase in a constantly changing pattern of responses to life-threatening situations.

PTSD and Gulf War-related illness

To date, no clear relationship has emerged between Gulf-related illness and PTSD. A recent study comparing UK Gulf veterans with non-disabled veterans of both the Gulf War (1991) and other contemporary conflicts found low rates of PTSD (1–3%).[13]

There is a consensus that an association exists between the symptoms of PTSD and ill-health in Gulf War veterans,[14] but this is not very strong, and is insufficient *per se* to account for the general increase in symptomatology reported by some veterans of that conflict. Characterized by medically unexplained symptoms, Gulf-related illness has also been shown to have much in common with post-combat disorders from earlier conflicts, such as shell shock, non-ulcer dyspepsia and effort syndrome.[15] However, there is no doubt that following the invasion and subsequent occupation of Iraq rates of PTSD amongst the US forces are high, and as we write are continuing to climb.[16] Initial estimates of the rates of PTSD amongst British service personnel returning from Op TELIC, the code name given for British operations in Iraq, though reservists (6%) had higher rates than regulars (14%)(see also pages 257–258).[17] ◆

REFERENCES

1 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM–III)*. Washington, DC: APA, 1980.

2 O'Brien L S. *Traumatic events and mental health*. Cambridge, Cambridge University Press, 1998.

3 Jones E, Wessely S. 'Forward psychiatry' in the military: its origins and effectiveness. *J Trauma Stress* 2002; **16:** 411–19.

4 Jones E, Wessely S. War syndromes: the impact of culture on medically unexplained symptoms. *Med Hist* 2005; **49:** 55–78.

5 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM–I)*. Washington, DC: APA, 1952.

6 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM–II)*. Washington, DC: APA, 1968.

7 Jones E. Historical approaches to post-combat disorders. *Phil Trans R Soc Lond B* 2006; **361:** 533–42.

8 Figley C R. Origins of traumatology and prospects for the future, Part 1. *J Trauma Pract* 2002; **1:** 17–32.

9 Scott W. PTSD in DSM-III: a case in the politics of diagnosis and disease. *Soc Probl* 1990; **37:** 294–310.

10 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM–IV)*. Washington, DC: APA, 1994.

11 Jones E, Hodgins Vermaas R, McCartney H *et al.* Flashbacks and post-traumatic stress disorder: the genesis of a twentieth-century disorder. *Br J Psychiatry* 2002; **182:** 158–63.

12 Young A. *The harmony of illusions, inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press, 1995.

13 Ismail K, Kent K, Brugha T *et al.* The mental health of UK Gulf War veterans: phase 2 of a two-phase cohort study. *Br Med J* 2002; **325:** 576–9.

14 Ford J, Campbell K, Storzbach D *et al.* Post-traumatic stress symptomatology is associated with unexplained illness attributed to Persian Gulf War military experience. *Psychosom Med* 2001; **63:** 842–9.

15 Jones E, Hodgins Vermaas R, McCartney H *et al.* Post-combat syndromes from the Boer War to the Gulf: a cluster analysis of their nature and attribution. *Br Med J* 2002; **324:** 321–4.

16 Hoge C, Castro C, Messer C, McGurk D, Cotting D, Koffman R. Combat duty in Iraq and Afganistan, mental health problems, and barriers to care. *New Engl J Med* 2004; **351:** 13–22.

17 Hotopf M, Hull L, Fear N T *et al.* The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet* 2006; **367:** 1731–41.

Practice points

- Post-traumatic illness is not an inevitable consequence of trauma
- Not all post-traumatic illness is PTSD
- PTSD is only one expression of an evolving response to trauma