Correspondence

EDITED BY STANLEY ZAMMIT

Flashbacks and PTSD

Jones *et al* (2003) claim to provide evidence that flashbacks in post-traumatic stress disorder (PTSD) are culture-bound because they were reported less frequently following earlier conflicts. They discuss the central issue of whether this was due to an under-reporting bias either because patients declared them less frequently or because doctors did not ask about them. In this discussion they conclude that this was not probable because the veterans were assessed frequently and because they were financially motivated by the prospect of a war pension. They have ignored the most important counter-argument that veterans of recent conflicts are most likely to over-report flashbacks in order to obtain compensation because: (a) the PTSD criteria are now publicised by the media; and (b) enquiry about flashbacks is now included in the routine clinical assessment of veterans.

A systematic study of exaggerating PTSD symptoms for compensation claims (Lees-Haley, 1997) indicates that at least 25% of present-day claimants overreport psychological symptoms. In earlier conflicts the post-trauma flashback symptom was mostly unknown by soldiers, clinicians or the media and there is no evidence of a 'compensation culture' at that time. Therefore, Jones *et al*'s finding probably has more to do with the cultural aspects of compensation and malingering than the cultural aspects of PTSD. In failing to deal with this important issue I do not believe the authors have provided sufficiently strong causal evidence for their conclusion 'that some characteristics of PTSD are culture-bound'.

Jones, E., Vermaas, R. H., McCartney, H., *et al* (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

Lees-Haley, P. R. (1997) MMPI-2 base rates for 492 personal injury plaintiffs: implications and challenges for forensic assessment. *Journal of Clinical Psychology*, **53**, 745–755.

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Jones *et al* (2003) draw conclusions that I believe are not entirely supported by the results of their study. The results show us that the percentage of flashbacks in post-combat syndromes is as low as 9%, thus challenging the credibility of flashbacks as a diagnostic sign for PTSD. Moreover, the study showed that only 9% of the soldiers with combat syndrome exhibit flashbacks.

The argument that PTSD is a culture-bound syndrome is quite overstated. It seems that somatic symptoms are far more widespread in PTSD than are flashbacks. These somatic symptoms stand at the base of traumatic syndromes. The link between PTSD and culture is weaker than we might think. Elbert & Schauer (2002) state that survivors from different cultures (Sudan and Somalia) exhibit psychiatric symptoms of PTSD. Jones *et al* (2003) state that many historical documents regarding trauma lack a common denominator, and they are right to some extent. However, I have shown (2001, 2002) that the somatic symptoms of nightmares, sleep disturbances and increased anxiety occurring as a response to traumatic events are symptoms that have not changed in 4000 years. There is some connection between trauma and culture, but this connection is mild at most. I do agree with Jones *et al* that PTSD is an evolving syndrome. In my opinion, the core of PTSD (somatic symptoms) is timeless and not culture-bound. However, other less-common symptoms are prone to some cultural influence.

Ben-Ezra, M. (2001) The earliest evidence of post-traumatic stress? (letter) *British Journal of Psychiatry*, **179**, 467.

— (2002) Trauma 4000 years ago? (letter) *American Journal of Psychiatry*, **159**, 1437.

Elbert, T. & Schauer, M. (2002) Psychological trauma: burnt into memory. *Nature*, **419**, 883.

Jones, E., Vermaas, R. H., McCartney, H., *et al* (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

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Nobody, I think, would doubt that the diagnosis and management of some mental illnesses, perhaps PTSD especially, is culture-bound. However, I think the paper on flashbacks by Jones *et al* (2003) is misleading.

A flashback is not defined in the glossary of technical terms in either DSM–III (American Psychiatric Association, 1980) or DSM–III–R (American Psychiatric Association, 1987). The only mention of flashbacks in DSM–III is as a complication of hallucinogen hallucinosis. It does appear in the diagnostic criteria (B3) for PTSD in DSM–III–R (in parenthesis) but the reader is referred in the index to post-hallucinogen perception disorder. Thus, while DSM–III refers to dissociative states and DSM–III–R refers to 'dissociative (flashback) episodes', both, in the context of the diagnosis, are described as rare. Thus, at the time of publication of these manuals, they were not a 'core symptom of PTSD'.

DSM–IV (American Psychiatric Association, 1994) retains 'dissociative flashback episodes' (without parenthesis) as one of the ways a traumatic event is persistently re-experienced, and in the glossary of technical terms defines a flashback as 'a recurrence of a memory, feeling, or perceptual experience from the past'. Thus, flashbacks, unless they are qualified as dissociative, have become synonymous with 'recurrent and intrusive distressing recollections of the events including images, thoughts or perceptions'. They do not even have to be intrusive. Such unpleasant memories are universal in combat veterans of any war. What has changed in this instance is how the term is used – not the phenomenon itself.

That 'earlier conflicts showed a greater emphasis on somatic symptoms' (Jones *et al*, 2003) indicates more clearly the impact of social values on symptomatology. Where a particular manifestation of

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distress meets with disapproval – the suggestion in these cases of lack of moral fibre or worse – somatic symptoms could be expected. In the early 1970s a Thai psychiatrist returning to Thailand from training in the USA indicated to me that he had to educate his patients before he could diagnose depression (P. Chaowasilp, personal communication, 1972). At that time, all his patients with depression presented with somatic complaints.

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM–III). Washington, DC: APA.

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Jones, E., Vermaas, R. H., McCartney, H., *et al* (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

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The study by Jones *et al* (2003) adds an interesting perspective on the concept of PTSD. However, there are methodological matters that concern me.

First, why are no subjects included from the Falklands Conflict of 1982? Jones *et al* cite O'Brien & Hughes (1991), whose work suggests that a much higher incidence of flashbacks might be found among that population.

Second, how many raters were used to confirm the existence of PTSD symptoms in the case records? What were the interrater reliabilities? How was any disagreement resolved?

Third, during my brief sojourn as Medical Member (Psychiatrist) of the War Pensions Appeal Tribunals, I studied in detail some 80 War Pension Agency case records, many for non-psychological cases. My overriding concern was the lack of symptom recording. Frequently, the relevant questions on War Pension Agency medical assessments concerning mental state received one-word answers, or were deleted entirely. How did these researchers deal with such cases?

Jones, E., Vermaas, R. H., McCartney, H., *et al* (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

O'Brien, L. S. & Hughes, S. J. (1991) Symptoms of post-traumatic stress disorder in Falklands veterans five years after the conflict. *British Journal of Psychiatry*, **159**, 135–141.

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Authors' reply: Leigh Neal has suggested that the increased incidence of flashbacks that we detected for Gulf War veterans is not a genuine observation but simply the result of contemporary overreporting. This effect he attributes to our 'compensation culture' and malingering. While we fully agree that claimants with PTSD may on occasion elaborate psychological symptoms for financial reasons, this factor is hardly novel (Wessely, 2003). There was, for example, an epidemic of war pension claims for shell shock and neurasthenia in the aftermath of the First World War. By March 1921, it was estimated that of the 1.3 million awards, 65 000 were for functional nervous disorders (Jones *et al*, 2002). So concerned was the Ministry of Pensions that applications were being falsified or exaggerated that they appointed Sir John Collie, an expert in rooting out fraud, to chair their 'special medical board for neurasthenia and functional nerve disease'. In 1917, Collie had included a chapter on the military in his textbook, in which he observed that 'the thin line which divides genuine functional nerve disease and shamming is exceedingly difficult to define' (Collie, 1917: p. 375). In fact, concerns about spurious or exaggerated claims for functional disorders pre-dated this conflict and followed the passing of the Workmen's Compensation Acts of 1897 and 1906. In the 6 years following the 1906 Act, the sums paid in accident compensation rose by 63.5% – despite the fact that the number of people in employment remained the same (Trimble, 1981). The research in the 1880s by Herbert Page to establish that most cases of railway spine were without organic basis was driven by the large settlements being paid by railway companies to passengers who had exaggerated or falsified symptoms following accidents. Indeed, the term *Rentenkampfneurosen* (pension struggle neurosis) had been coined following Bismarck's accident insurance legislation of 1884 and reflected widespread concerns that workers and passengers were defrauding companies through dubious medical claims (Lerner, 2001).

Other than agreeing that these things can and do happen, it is always risky to make statements about the incidence of malingering, as clinicians have no particular expertise in its measurement. Dr Neal has no more information than we have, or anyone else for that matter, on the true rates of malingering, let alone whether or not it is increasing. What the above does show is that concern about the phenomenon is certainly not new.

Menachem Ben-Ezra rightly points out that the flashback is a comparatively rare symptom among PTSD sufferers. He argues that other symptoms, such as nightmares, sleep disturbance and elevated anxiety, are common and enduring features, and, therefore, not culture-bound. While we agree that these symptoms were widely reported in the past, their existence *per se* does not justify the creation of a new and very specific disorder. The complex diagnostic criteria for PTSD in DSM–IV (American Psychiatric Association, 1994) comprise six sub-groups, which extend over three pages. Anxiety, sleep disturbance and nightmares are not disorders in themselves, as most people suffer from them at some time. It is only when they become severe or arise inappropriately that psychiatrists elevate them to psychiatric disorders. With the exception of hallucinogen persisting perception disorder, flashbacks are almost unique to PTSD. As a result, we chose this symptom as a way of trying to evaluate the incidence of this modern diagnosis. It should not be forgotten that PTSD did not enter DSM–III (American Psychiatric Association, 1980) as a result of a series of rigorous epidemiological investigations but in the context of an anti-war movement, which sought to demonstrate that servicemen suffered long-term effects from combat. Only after it had been formally recognised by the American Psychiatric Association was PTSD then subject to intense scientific analysis (Young, 1995).

Dr Burges Watson has identified not only the growing significance attached to the flashback but also the disparity between the way that flashbacks are described as part of the diagnostic criteria for PTSD and in the DSM–IV glossary. In the former, they are included within 'acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes…)', while the latter contains a brief definition: 'a recurrence of a memory, feeling, or perceptual experience

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