

Cultural shift in mental illness: a comparison of stress responses in World War I and the Vietnam War

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Summary

Objectives: Post-traumatic stress disorder is an established diagnostic category. In particular, over the past 20 years, there has been an interest in culture as a fundamental factor in post-traumatic stress disorder symptom manifestation. However, only a very limited portion of this literature studies the historical variability of post-traumatic stress within a particular culture.

Design: Therefore, this study examines whether stress responses to violence associated with armed conflicts have been a culturally stable reaction in Western troops.

Setting: We have compared historical records from World War I to those of the Vietnam War. Reference is also made to observations of combat trauma reactions in pre-World War I conflicts, World War II, the Korean War, the Falklands War, and the First Gulf War.

Participants: The data set consisted of literature that was published during and after these armed conflicts.

Main outcome measures: Accounts of World War I Shell Shock that describe symptom presentation, incidence (both acute and delayed), and prognosis were compared to the observations made of Vietnam War post-traumatic stress disorder victims.

Results: Results suggest that the conditions observed in Vietnam veterans were not the same as those which were observed in World War I trauma victims.

Conclusions: The paper argues that the concept of post-traumatic stress disorder cannot be stretched to cover the typical battle trauma reactions of World War I. It is suggested that relatively subtle changes in culture, over little more than a generation, have had a profound effect on how mental illness forms, manifests itself, and is effectively treated. We add new evidence to the argument that post-traumatic stress disorder in its current conceptualisation does not adequately account, not only for ethnocultural variation but also for historical variation in stress responses within the same culture.

Keywords

post-traumatic stress, culture, cultural shift, historical change, the same culture, universality, battle trauma, Vietnam War, World War I

Introduction

Exposure to stressors has been linked with the potential development of psychological trauma.¹ According to current nosological systems, psychological trauma can be briefly defined as a response to an exceptionally catastrophic event, such as military combat, that threatens the integrity of the person. Clinically, post-traumatic stress disorder is an established conceptualisation of stress-induced psychopathology. Historically, the conception of post-traumatic stress disorder as a diagnostic concept first presented in Charles Figley's *Stress Disorders among Vietnam Veterans*,² and signifies so-called battle trauma. Figley's work reflected more than a decade of research on the symptoms of psychological abnormality and distress exhibited by U.S. Vietnam veterans.

A central proposition by Figley et al. was that post-traumatic stress disorder is diagnostically robust. A key argument was that post-traumatic stress disorder was the same condition that was described in other armed conflicts, although its terminology changed from soldier's heart (American Civil War) to shell shock (World War I), War Fatigue (World War II) to combat stress (Vietnam War). Thus, it was proposed that post-traumatic stress disorder presented not as a new mental disorder, but as a universal, time-independent, psychological response to stress that had been rediscovered.

Figley's claim was predominantly accepted by the U.S. Psychiatric and Psychological establishment, and post-traumatic stress disorder as a diagnostic concept received the imprimatur of the American Psychiatric Association in 1980 by being included in the third edition of its diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders*. The tenth version of the WHO's classification system of diseases, the *International Statistical Classification of Diseases and Related Health Problems*, also accepted post-traumatic stress

disorder with slightly inexact diagnostic criteria. By the early 1980s, the concept of post-traumatic stress disorder had spread to the civilian population, was being used internationally, and generating vast quantities of research, becoming possibly the most popular and acceptable mental illness diagnosis in history. Research has extended from Vietnam War veterans to victims of other wars and civilian traumatic events.

The conceptual validity of post-traumatic stress disorder as a diagnostic category has been criticised since its epiphany.³ One stream of criticism considers culture as a fundamental factor mediating the manifestation of post-traumatic stress^{4,5} and questions its cross-cultural applicability.⁶ Many publications in this perspective address the often implicitly assumed universal validity of post-traumatic stress disorder.

So far, only a very limited portion of the literature that criticises the conceptual validity of post-traumatic stress disorder, and specifically the sensitivity of this mental disorder to cultural influence, takes into account the historical variability of stress responses to the same kind of stressors *within a particular culture*.⁷ This is in contrast with the majority of studies that consider post-traumatic stress *in diverse traditions across cultures* and criticise the cross-cultural applicability of the concept. We offer evidence for the argument that post-traumatic stress disorder in its current conceptualisation inadequately accounts for not only cross-cultural variability but also for the historical variance of stress responses within the same culture. For this purpose, we delineate how traumatic stress responses associated with armed conflict have changed historically within one cultural tradition.

Methods

To examine whether combat stress reactions in Western troops have changed historically between World War I and the Vietnam War, accounts of World War I shell shock that describe symptom presentation, incidence (both acute and delayed), and prognosis were compared to the observations made of Vietnam War post-traumatic stress disorder victims. The data set consisted of literature that was published during and after these armed conflicts. Reference is also made to observations of combat trauma reactions in pre-World War I conflicts, World War II, the Korean War, the Falklands War, and the First Gulf War.

Results

Symptom presentation

WH Rivers,⁸ perhaps one of the most famous of World War I military psychiatrists, noted paralysis

as the most common consequence of shock. Smith and Pear⁹ state disturbances of sensation and movement as the most apparent phenomena of shell shock. In fact, somatic and conversion hysteria symptoms dominate the contemporary descriptions of World War I shell shock.^{8–10} Some symptoms correspond with those of post-traumatic stress disorder as it was described in the third version of the *Diagnostic and Statistical Manual of Mental Disorders*. The most clear ones are those that are included in the hyperarousal subcategory, for instance, insomnia and exaggerated startle response, and also common are nightmares and flashbacks, within the intrusion subcategory. Such symptoms were typically observed in post-Vietnam War post-traumatic stress disorder and were also commonly recorded in World War I shell shock cases. But these symptoms are invariably part of an acute reaction in World War I, whereas in Vietnamese War post-traumatic stress disorder, such symptoms were observed as part of delayed, chronic reactions. It appears that the somatic conversion symptoms that dominated the presentation of trauma reactions between 1914 and 1918 had completely disappeared from the Vietnam War reactions 50 years later.

Combat stress reactions recorded from the conflicts of the mid-20th century (World War II and the Korean War) are broadly noted to be of an intermediate nature. Somatic and hysterical symptoms were still typical but less frequent than in World War I and also generally less extreme.¹¹ Regarding subsequent conflicts, the complaints presented by British and U.S. troops from the first Gulf War are not entirely elucidated: the ‘Gulf War Syndrome’. Nevertheless, there is the suggestion that this syndrome represents a shift in the reaction to psychological trauma – a shift back to somatic reactions but of different forms and with much greater chronicity than in World War I.¹²

Incidence

As early as December 1914, an editorial from *The Lancet* had noted with alarm that it was not only Belgian troops who were succumbing to hysterical conditions at the front line, but also British officers and men!¹³ Field Marshal Haig complained that he was short of two divisions (around 40,000 men) from the Western Front at any given time, because of shell shock.

A variety of factors deem an exact computation of troop casualties caused by traumatic stress impossible. However, an arguably conservative approximation from Kogan¹⁴ put the total number of British psychiatric casualties (for which traumatic stress may be assumed

as one of the most prevalent causes) from the Western Front between 1914 and 1918 at 80,000, i.e. around 4% of those that survived the war. Strecker¹⁵ estimates the incidence of shell shock in the U.S. expeditionary force in France to be around 10%.

By contrast, acute combat trauma reactions in the Vietnam War were almost unknown. Indeed, a view was expressed that methods adopted by the U.S. military to screen out those with neurotic dispositions, and to reduce stress at the front line, had all but eradicated combat stress reactions.^{16–22} Delayed reactions began to manifest in the Vietnam War veterans from the point of their discharge, and this promoted the research that eventually aided the definition of post-traumatic stress disorder. By 1990, the *National Vietnam Readjustment Study* by Kulka et al.^{23,24} revealed 26% of the Vietnam War veterans were fully or partially suffering from symptoms of post-traumatic stress disorder. Jones and Wessely⁷ have also commented on the low incidence of acute combat reactions in the Vietnam War as opposed to long-term (delayed) psychiatric casualties. Ørner et al.,²⁵ in a controversial study, claimed that 63% of Falklands War Veterans were suffering from post-traumatic stress disorder.

Prognosis and treatment

Accounts published by British, French, and U.S. military psychiatrists of World War I consistently recount shell shock cases, in the most part, recovering after relatively short periods of time (weeks or months) with the help of simple treatments. For instance, Rivers⁸ describes the use of Charlie Chaplin films to cure some cases – the success being attributed to the abreactive effect of laughter.³³ Captain Myers²⁶ – who coined the term shell shock – reported ‘striking success’ with hypnosis. Smith and Pear⁹ state that simple explanations are, in most of the cases, sufficient to cause a substantial change in the clinical condition. Captain William Brown²⁷ reported 70% of his shell shock cases returned to duty within two weeks. Furthermore, the French psychiatrist André Léri²⁸ claimed that in 1916, 91% of his patients returned to the front line. In comparison, 62% of U.S. shell shock cases were reported to have been able to return to duty.²⁹

Relating to the more chronic cases, British war pension records suggest that most cases naturally remitted in the decade following the war. Eric Coplans,³⁰ the physician in charge of the Ex-Services Welfare Society dealing with enduring cases of shell shock in the London area, observed 527 cases between 1926 and 1930 and seemed able to cure most of them with the

help of simple supportive counselling and occupational therapy.

It would be beyond the scope of this paper to comprehensively analyse the vast literature on the outcome studies for Vietnam War-related post-traumatic stress disorder. But it would be beyond contention to say that (1) there is no strong evidence to suggest that the condition naturally ameliorates without treatment; and (2) mixtures of sophisticated psychiatric and psychological treatment, even in the long term, do not meet with total success.² Certainly, no clinician could be confident of rehabilitating a Vietnam Veteran of post-traumatic stress disorder simply by giving him a good laugh.

Discussion

Historical evidence suggests that in the period between World War I and the Vietnam War, there was a considerable change in the way military personnel reacted to traumatic stress, within Western troop populations. Apart from the dissimilarities in incidence, prognosis, and effective treatments (which may suggest two different ‘disease’ processes), it is observed that the dominating conversion symptoms of shell shock are not simply a cultural variation of those found in post-traumatic stress disorder but are entirely lacking in the latter. Differences in symptom presentation together with differences in incidence (acute and delayed) and prognosis suggest not that we are dealing with two ‘stand-alone’ diseases (conversion hysteria say, and post-traumatic stress disorder) but that the whole way of processing shock within Western populations in 1914 had shifted by 1964. Furthermore, there is evidence that other mental disorders have also significantly changed their presentation and dynamic with time (e.g. Murphy’s work on depression³¹).

However, comparisons between World War I and Vietnam trauma reactions indicate a possible universal biological reaction to traumatic stress that is manifested in hyperarousal symptoms. It is proposed that such reactions may excite culturally specific psychological responses that profoundly shape the resulting illness. From a psychoanalytical viewpoint, it is reasonable to advance the view that the somatic conversion symptoms that commonly manifested in World War I served as a defence mechanism. It may be argued that this defence mechanism effectively protected sufferers from enduring longer and more deeply fracturing stress; producing higher numbers of acute, easily-treatable conditions, and much lower numbers of delayed, chronic conditions than from the Vietnam War. The symptom difference is not just cultural spume but is dynamically related

to the entire procedure of processing trauma, which it seems Western troop populations were better able to do in 1914 than in 1964.

Conclusion

Our study suggests that the concept of post-traumatic stress disorder cannot be stretched to cover the typical battle trauma reactions of World War I. Our view is that relatively subtle changes in Western culture, over little more than a generation, have had a profound effect on how a mental illness forms, manifests itself, and is effectively treated. We have found no evidence to suggest that the differences found between World War I shell shock and Vietnam post-traumatic stress disorder simply reflect a change in psychiatric symptom categorisation, as Kleinman³² has argued, to explain the apparent disappearance of neurasthenia in the West in the 1950s. As such, we argue that post-traumatic stress disorder (as defined in international nosologies) cannot be safely regarded as a historically stable mental disorder.

Declarations

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