

Correspondence

EDITED BY STANLEY ZAMMIT

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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.

L. A. Neal Bristol Priory Hospital, Heath House Lane, Stapleton, Bristol BS16 1EQ, UK

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.

M. Ben-Ezra Department of Psychology, Tel-Aviv University, PO Box 39040, Tel Aviv 69978, Israel.
E-mail: menbe@post.tau.ac.il

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