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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from the past' (American Psychiatric Association, 1994: pp. 428, 766). Dr Burges Watson infers from this that the flashback is a new term for an old phenomenon; what in the past would have been described as a vivid memory of conflict is today called a flashback. The objection to this hypothesis is that we discovered both phenomena in medical records from the First and Second World Wars. We were careful to adopt a rigorous definition of flashback (which included the sense of reliving the traumatic episode) to distinguish it from eidetic memories.

In answer to Dr Hambidge, we were unable to include veterans of the Falklands War because ministerial permission was not granted to study recent war pension files of service personnel still living, and because the Medical Assessment Programme is limited to veterans of the Persian Gulf War. As regards the collection of data, three research assistants recorded symptoms on a standardised form by copying verbatim from medical notes. These were then reviewed in detail by the lead investigator, who re-examined the files to ensure accuracy and consistency of interpretation. War pension files with missing information were excluded from the study. In general, the case notes were comprehensive, often detailing a serviceman's history from enlistment until death. As these are a continuous series of records, there is no reason to suppose that deficiencies in reporting were confined to modern assessors rather than being spread randomly throughout the archive.

Declaration of interest

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Human rights and mental health

I agree with Bindman *et al* (2003) that, to date, the jurisprudence of the European Court of Human Rights has not set a 'high standard' for modern mental health services. This is apparent not only in areas of the process of detention and its lawfulness, but also in areas of treatment standards and material standards of the facilities in which people are detained. I would also echo their sentiment that the wording of article 5(1)e of the European Convention on Human Rights is at best unfortunate and at worst deeply stigmatising. That said, I believe that the doctrine of the 'living instrument' (*Tyrer v. United Kingdom*, 1978; Reed & Murdoch, 2002) in Strasbourg jurisprudence is of fundamental importance in interpretation of the Convention and may yet lead to improved protection of the human rights of both patients with mental illnesses and people with learning disabilities.

With respect to patients who are *de facto* detained, the case of *Rierra Blume v. Spain* (1999) may improve rights protection. Here, the European Court of Human Rights ruled that the complainants, who had been escorted by the police to receive, among other things, psychiatric treatment, had been *de facto* detained and that their detention was unlawful. However, many patients for various reasons, especially non-protesting patients as in the Bournewood case (*R v. Bournewood Community and Mental Health NHS Trust*, 1998), will not take cases to the courts, and the protection of their rights may depend on relatives or voluntary organisations acting on their behalf.

Legal protection with regard to the autonomy of patients with mental illnesses and people with learning disabilities may improve by a back-door means, arising from the debate over privacy protection and article 8 rights ('right to respect for private and family life'). However, rights can be secured in court only if challenges are brought, and many people with mental illnesses or learning disabilities may not have the awareness or the means to bring such challenges. The importance of ways other than legislation for highlighting and securing rights, such as the Royal College of Psychiatrists' anti-stigma campaign 'Changing Minds', education campaigns about mental illness and the work of numerous voluntary agencies, cannot be underestimated in promoting equal rights and opportunities for these population groups.

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Tyrer v. United Kingdom (1978) 2 EHRR 1.

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Slavery and psychiatry

Raj Persaud (2003) begins his review of Thomas Szasz's book *Liberation by Oppression: A Comparative Study of Slavery and Psychiatry* by asserting that something false is true: 'Thomas Szasz became famous for being at the vanguard of the anti-psychiatry movement'. First, Szasz has never been part of the anti-psychiatry movement, much less at the vanguard of it. Second, there is as much truth in Persaud's assertion as there is in asserting that the Nazis were simply practising medicine. Szasz has made it absolutely clear for over 50 years now that he supports psychiatry between consenting adults, that is, he supports contractual psychiatry. Third, Dr Persaud then asserts that Szasz is an 'ally rather than an enemy of the National Health Service general adult psychiatrist'.

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