The History of Psychological Trauma

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The book, "The History of Psychological Trauma," written in Hebrew, presents to the reader the developmental history of the term "psychological trauma" through emphasis on military trauma, and includes references to terrorism, traumatic grief, and historical events that unite the country of Israel. The historical journey which the reader travels enables understanding of how and why the notion "psychological trauma" evolved and how it is treated. Reading this book will deepen the reader's factual historical knowledge of the topic through a uniquely meaningful and individual emotional experience. This is made possible by a writing style that is captivating, pictures that embolden the book and bring it to life, and via a broad and humanistic analysis that integrates the facets of the individual, social, systemic, medical and psychiatric worlds.

In reading this book, one may develop an understanding of how such a common human experience such as "psychological trauma" is actually a relatively newly understood social and medical term. By reading the book chronologically, the reader can see history unfold through a series of significant historical events, starting from the 19th century until today. The historical events are presented from an investigative perspective. In other words, the book does not just offer a documented summary of the events that occurred, but rather also presents those things that did not occur or were not documented during the event although it would seem logical that they should have been. This perspective is essential in order to encourage the reader to be challenged with questions that still generate much controversy among researchers, therapists, actuaries and laymen – does psychological trauma cause psychopathology, and is the diagnosis of Post-Traumatic Stress Disorder in fact real? We will not spoil the book with "answers," but it is worthwhile emphasizing how well balanced the writing is in presenting a past that teaches us numerous lessons from a variety of perspectives.

In an attempt to illustrate how the book consistently reveals to the reader the nonlinear development of the concept of "mental trauma", this review is also chronological. It begins in the period before World War I, continues through the World War II and ends in the era thereafter. For the sake of brevity, the review does not include the important processes of World War II, the Vietnam War, when the diagnosis of PTSD was established in the DSM, nor the Israeli experience of dealing with the trauma stemming from terrorism.

The first part of the book deals with the subject of traumatic neurosis in the 19th century and the various concepts used at that time.

In light of the technological developments of the 19th century, many people were exposed to extreme levels of physical stress. This was until the massive number of patients and the intensity of the suffering challenged the existing medical knowledge that did not include thinking in psychological terms.

For example, with the development of modern railways (1825 onwards), the victims of railway accidents also appeared. Some of the victims had symptoms of weakness, insomnia, and intolerance to train traffic even though there was no evidence of physical injury. The issue of treatment and compensation for such casualties raised the questions: What caused the symptoms? How should they be treated? The notion that trauma caused the symptoms (e.g., by pathologist Ambrose Tredio 1860, psychiatrist Herman Oppenheim 1889) was met with skepticism by the medical community. Skepticism was directed at both doctors and their patients who were described as suffering from "pension neurosis" (as described in Germany in following Bismarck's development of accident insurance and disability pension) or "false memories" (as described in France regarding the investigation of child sexual abuse).

In the United States, Jacob Mendez de Costa, who worked as a physician in a military hospital during the American Civil War (1861-1865), described a cardiac disorder called "irritable heart" or "soldier's heart" in which soldiers suffered from palpitations, chest pain and shortness of breath. They were treated with digitalis, a substance derived from the foxglove plant, which has been a mainstay in the treatment of heart disease – in particular, heart failure and atrial fibrillation. Another diagnosis that was used to describe the condition of the soldiers was "nostalgia" – the pain of wanting to return home, a term coined by Johannes Hopper in 1688 to describe the mental deterioration of soldiers stationed far from their homes. The military doctors in the Boer War (1881) used the diagnosis of "debility" to describe soldiers who suffered from general nervous exhaustion and dysfunction in the absence of organic findings. Even in the Russo-Japanese War (1904-1905) when Russian psychiatrists were involved in treating soldiers with "strange

symptoms of unclear origin," officers and policymakers saw the diagnosis of "war neurosis" or mental exhaustion as a deception by the troops to mask their cowardice and avoid fighting in the front lines.

The second part of the book traces the development of the understanding of psychological trauma in World War I.

World War I was also called the Great War (1914-1918 and extended until 1920). It was the first war that used modern technologies such as tanks, machine guns and chemical weapons. Various countries diagnosed and managed the treatment of trauma victims in different ways.

In the United Kingdom: As the fighting progressed, the British War Office was updated on the trend of soldiers and officers who were evacuated back to the UK because of "nervous and mental shock casualties." The evacuees were 7-10% of the officers and 4-3% of the other ranks. There were reports of soldiers "freezing under shell-fire," some of whom had unusual symptoms such as limb paralysis, deafness and blindness, with a psychological background. Because in the British Army Medical Corps there were only the following categories: healthy, sick, wounded, insane, feigning illness/cowardice – the symptoms described earlier seemed like an unrecognized and complex disease and posed a difficult challenge to British medical services. Doctors such as Charles Myers began treating and investigating these cases. In 1915 Myers published an article in the medical journal, The Lancet, which was the first professional journal to use the term that was probably used spontaneously by the soldiers – "Shell Shock." Myers stated that because the symptoms of shell shock could appear even when the soldier was far from the exploding shell – the effect of the explosion did not depend on the physical or chemical impact of the exploding shell, but rather was caused by severe emotional damage or severe mental stress.

Aside from the etiological questions, there arose questions regarding therapy. Just as there was no consensus regarding etiology, there was no consensus regarding treatment methods.

The neurologist Gordon Holmes noted that 30%-40% of the patients treated in France near the battlefield returned to service and only 3%-4% of those treated in England returned to service. In accord with this observation, in 1916, treatment centers were designed to receive casualties directly from the battlefield, and allowed for a short respite for eating and rest and gradual physical exercise that would conclude with a return to the front.

The psychologist and psychiatrist William Brown reported that 70% of the patients treated within 48 hours from the moment that they developed neurasthenia returned to active duty after about two weeks of rest that included vigorous convincing of the patient of the true source of his symptoms with spontaneous emotional processing of the painful memories, while creating an atmosphere of confidence, faith and expectation that the patient would be capable of returning to active duty.

The neurologist Lewis Ralph Yealland believed that the source of the symptoms of war neurosis were psychogenic and resulted from lack of willpower and negativism towards recovery (which was not necessarily conscious) and hyper-suggestivity. His treatment focused on the physical level, but incorporated authoritative suggestion that aimed to instill in the patient recognition that his difficulties were physical and with treatment the body could overcome them. In clinical situations that manifested in inactivity, such as limb paralysis – treatments were with increased electrical current that, according to his case descriptions, resulted in the limbs returning to function. There were case descriptions of patients that recovered once they were informed that they were about to undergo treatment!

Psychiatry in the United States Shipping Corps.

With the entrance of the United States in the World War I, Thomas William Salmon was sent to Europe to investigate the methods used by France and Great Britain to treat war neuroses. The report published in October 1917 greatly influenced American assessments of the war. The report recommended the following: Strict selection of recruits (72,000 of those drafted for service were found unfit and were discharged); appointment of a division psychiatrist whose job it was to advise medical officers; establishment of frontline psychiatric hospitals within four to six miles of the front line, in accord with the principle of "Proximity, Immediacy, Expectancy (PIE) Treatments." These hospitals had 150 beds and allowed for 3-10 days of inpatient care. This model was later adopted in Israel and is known as "Salmon's Rules." It is noteworthy that the theoretical concept of treatment of psychological trauma on the front line, "frontline therapy," was apparently developed by the French – Georges Guillian and Marcel Briand in 1915.

Central Powers, especially Germany: The neurosis of war and coping with it.

Mentally wounded German soldiers were evacuated, and they soon filled the hospitals. In the absence of proven treatment techniques, significant frustration was created among psychiatrists and neurologists until a sense of "crusade" was created against the hysteria. This situation formed the basis for the development of therapeutic techniques based on suggestion, surprise, intimidation and persuasion of the patients. For example, there were irradiating paralyzed organs with laser beams to return them to function, electrifying paralyzed organs to return them to activity, and treatment with "miracle drugs" that the patients were told were given under anesthesia to bring about recovery from hysterical symptoms. The success rates of these techniques were high (90%) and brought their caregivers pride in their success and contribution to the war effort. However, these successes were accompanied by criticism from patients and the public and as expressed in lawsuits in the courts.

Appendix: True or not – Did Hitler suffer from war neurosis in the form of hysterical blindness?

In the last week of World War I, Hitler was hit by a gas grenade (probably mustard gas); he had signs of swelling in the eyelids, redness and skin irritation. Hitler was in a field hospital but due to a complaint of a blindness that was diagnosed as non-organic he was sent to a military psychiatric hospital called Pasewalk. After two days there he was informed that the war had ended in German defeat (as he documented in his book "Mein Kamf") and was released after a 19-day stay, with a diagnosis that he was fit for service and he returned to his base. Although Hitler himself documented his experiences as wounded, his medical record was not found. There is also documentation of a report by a Jewish doctor named Kroner (who fled Germany after Kristallnacht) about his observation in a medical examination performed by Dr. Foster of Hitler (record shows that Dr. Foster committed suicide in 1943 with a gun he was not known to have). The examination revealed that Hitler was diagnosed as "a psychopath with hysterical lines and suffering from a feeling of inferiority, which is conditioned by a predisposition of hereditary factors, weakness and inability to adapt to society."

The third part of the book seeks to identify how to deal with mental trauma in the absence of active warfare, followed by further combat.

It is widely argued that the development of modern warfare has had a decisive impact on the development of psychiatry — for example, Freudian ideas about neurosis have been accepted in the mainstream of psychiatry and the general public, such as the recognition that men (and not just hysterical women) have a psychic world. However, despite the knowledge that has become commonplace, the (conscious and unconscious) desire of caregivers and patients to forget the war and the difficult struggles that accompany it have led to the lessons of dealing with the war being forgotten and gone. This can be seen in the developments between the First and Second World Wars in Britain.

Two years after the armistice, there were at least 65,000 former military personnel in England who were entitled to a disability pension due to a diagnosis of neurasthenia, 9,000 of whom were still being treated in hospitals. The "shell shock" phenomenon challenged the understanding of the relationship of the human psyche and health with financial implications in retirement issues. In 1922 the report of the War Office Committee of Enquiry into "Shell-Shock" was written. The committee avoided the issues of the causes of the disorder, and thus also avoided the question of who was responsible and who should pay for the consequences. The committee, however, did establish recommendations to avoid the recurrence of the "shell shock epidemic." Among them were recommendations to avoid using the term "shell shock" or "battle fatigue" and diagnose only "illness." Strictly screen future recruits in terms of mental health, and ensure that training is more comprehensive with appropriate leadership to improve mental resilience, and confirm that the medical corps have specific guidelines on how to treat the mentally ill and a group of trained medical officers to teach the subject.

The implications of the report included the following: The concept was established that resilience and mental and nervous stability are important factors in modern warfare. The military concluded that good training would provide a sufficient basis for future prevention (i.e., if "shell shock" can be prevented, then there is no need for military psychiatry). The term "shell shock" ceased to appear as a medical diagnosis and became a literary and cultural metaphor for the experiences of the difficult war.

In September 1939 the officers of the Royal Medical Corps were briefed on the war neuroses and their treatment. A strict policy of not pensioning off people suffering from these disorders and of not using the term "shell shock" as a diagnosis was employed.

It is difficult to summarize a book so rich in facts and meanings. However, it is worth emphasizing how

clearly the book is written, and how the questions that the book raises do not allow for trivial answers.

Accordingly, we conclude with a quote from Lord Southbro's book from 1922:

> "the study of the subject was difficult and did not involve any pleasure, all we want is to forget and forget ... the madness, suicide, and death, to bury all the memories of this terrible disease and on the surface only to cherish the memory of the victims. But gentlemen, we cannot do this because a very large number of cases suffering from 'shell shock' and similar disorders are still with us, dependent on us and in need of our sympathy, attention and treatment."

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