

# A paradigm shift in the conceptualization of psychological trauma in the 20th century

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## Abstract

The inclusion of posttraumatic stress disorder (PTSD) in *DSM-III* in 1980 represented a paradigm shift in the conceptualisation of post-trauma illness. Hitherto, a normal psychological reaction to a terrifying event was considered short-term and reversible. Long-term effects, characterized as “traumatic neurosis”, were regarded as abnormal. Enduring symptoms were explained in terms of hereditary predisposition, early maladaptive experiences or a pre-existing psychiatric disorder. The event served merely as a trigger to something that existed or was waiting to emerge. Secondary gain, the benefits often but not solely financial that a person derived as a result of being ill, was considered the principal cause of any observed failure to recover. The recognition of PTSD reflected a diversion from the role of the group, in particular the “herd instinct”, towards a greater appreciation of the individual’s experience. From being the responsibility of the subject, traumatic illness became an external imposition and possibly a universal response to a terrifying and unexpected event. This shift from predisposition to the characteristics of the event itself reduced guilt and blame, while the undermining of secondary gain made it easier to award financial compensation.

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The formal recognition of posttraumatic stress disorder (PTSD) in 1980 represented a paradigm shift in the way that psychiatric trauma was interpreted (APA, 1980). Hitherto, it was argued that if a healthy individual suffered psychological effects as a result of a life-threatening event, these would resolve themselves naturally, like a self-healing wound, with no long-term effects. The discovery of a so-called “delayed stress syndrome” during the Vietnam War appeared to show that healthy soldiers subjected to the trauma of combat could suffer chronic, adverse effects that were not apparent at the time of their exposure (Figley, 1978).

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Before the 1970s, anyone who suffered long-term psychiatric effects after a frightening event was considered constitutionally predisposed to mental illness or subject to a repressed childhood trauma; in either case, responsibility lay with the individual. The event itself served merely as a trigger. With the recognition of PTSD, primary causation transferred to the terrifying experience and any exposed individual was largely absolved from blame or responsibility. The new concept of psychological trauma also saw the retreat into obscurity of “secondary gain”, the attention and benefits that a patient received as a consequence of suffering from a recognized psychiatric disorder.

PTSD reflected a cultural shift from the group towards the subject. Psychological casualties in both World Wars were, in part, considered a failure of training, unit cohesiveness, leadership and morale (Wessely, 2006). PTSD was a product of a society in which the emphasis had moved from the duties of a citizen towards the rights of an individual. The new diagnosis was also designed to fill a gap created by loss of “gross stress reaction”, a disorder introduced by *DSM-I* (American Psychiatric Association (APA, 1952)) but not included in *DSM-II* (1966). Andreasen believed that a period of relative peace between the end of World War Two and the outbreak of the Vietnam conflict sixteen years later had led to a “foolish optimism” that such a category was no longer needed (Andreasen, 1980, p. 1518). In this paper, we explore how mental health professionals continually reinterpreted psychological trauma in response to wars, disasters and cultural undercurrents.

## 1. The conception of psychological trauma in the early 20th century

During the 19th century, with the exception of psycho-analytical literature, the word “trauma” generally referred to an open wound or violent rupture to the surface of the skin; it carried no psychological connotations. If, for example, a soldier broke down on campaign, he was deemed either to have succumbed to major mental illness, such as melancholia or dementia praecox, or to be suffering from the side effects of climate or disease (Jones & Wessely, 2005). The idea that a soldier of previously sound mind could be so emotionally disturbed by combat that he could no longer function was not entertained; that he might suffer long-term psychological consequences of battle was also dismissed. As a result, it was believed by British military physicians that “no war neuroses were observed in the Boer War”, the first “traces” being detected by Royal Army Medical Corps’ doctors sent to observe the Russo-Japanese War of 1905 (Stanford Read, 1920, p. 143).

### 1.1. *Traumatic neurosis*

The hypothesis that a terrifying event might have effects other than the purely physical had been proposed in the aftermath of the Franco-Prussian War (1870–1871). In 1882 wards dedicated to the treatment of men with hysteria were opened at the Salpêtrière. There Jean-Martin Charcot (1825–1893), a neurologist, identified a wide range of common but seemingly inexplicable symptoms including: palpitations, exhaustion, chest pain, dizziness and fainting, headache, back pain, trembling of the hands and neck, difficulty sleeping and mental disorientation. Among his patients were a number of ex-servicemen troubled almost a decade after the conflict had ended. One veteran, who he termed “D-ray”, had fought in the Mexican and Franco-Prussian Wars, and suffered from a range of symptoms including nightmares of his wartime experiences (Micale, 2001). Devising new diagnostic terms, “*névrose traumatique*” and “*hystérie traumatique*” to classify these cases, Charcot concluded that an event, such as a railway

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