Does PTSD Really Exist?
On Trauma, Trauma Culture, and Trauma Abuse

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Posttraumatic stress disorder (PTSD) is one of the showpieces of present-day psychiatry and clinical psychology. By now, partly due to the efforts of ICODO, the notion has attained the status of received wisdom in the Netherlands; it has become common terminology in the media and common parlance among the general public. It has been included in the standard international system for classifying psychiatric disorders, the Diagnostic and Statistical Manual of Mental Disorders (in short, DSM). But is it real? Several recent issues, debates, and publications have raised some doubts. A few years ago, for instance, there was the affair surrounding the discredited former member of the Dutch parliament, Tara Singh Varma, whose web of lies about a presumably fatal breast cancer was explained in a public statement by Varma’s legal representative and attending psychiatrist in psychiatric terms as a PTSD, which immediately generated a new controversy.¹

An intensive Internet debate took place in 2001 in reaction to a paper in the British Medical Journal in which a psychiatrist well known for his publications on PTSD, Derek Summerfield, had flatly denied that PTSD exists.² Ben Shephard, an English journalist and historian, wrote a beautiful book in which he draws the same conclusion on the grounds of his thorough study of the conceptual development of the diagnosis of trauma, ranging from ‘soldier’s heart’ to PTSD, mainly in a British setting.³ The field of transcultural psychiatry has kept generating a critical literature on PTSD – some of it well founded, some of it written with ideological blinders.⁴ And recently, the present author published research on the history of Dutch thinking about the war trauma from 1945 to 2000, which also led to questions about the current status of PTSD and especially about the trivialization of the word trauma.⁵

¹ The Varma affair prompted so many newspaper articles that any attempt to list them here would be out of the question. Specifically on the diagnosis of PTSD, see Jolande Withuis, “Stress-stoornis bij Singh Varma is ongeloofwaardig” [Singh Varma’s stress disorder implausible], NRC Handelsblad, 4 August 2001.


⁴ There are too many sources to mention. See for instance the last several volumes of the Dutch mental-health journal Maandblad Geestelijke volksgezondheid. For an analysis of the themes dominating the discussion in this area, see Jolande Withuis, ‘Cultuur en trauma. Kanttekeningen bij enige recente publicaties over vluchtelingenzorg’ [Culture and trauma. Observations on some recent publications on care for refugees], in ICODO-info vol. 14 (1997)1, pp. 55-77.

Trauma

Posttraumatic stress disorder has not been officially recognized as a disorder for very long. In fact, it was not so long ago that the word ‘trauma’ – when not referring to an early childhood trauma – was understood primarily or even exclusively in a physical sense. Casualties from traffic accidents were taken to a hospital's trauma ward, and those traumas called for surgeons. Indeed, the 1956 edition of the standard Dutch dictionary (Van Dale) defined ‘trauma’ merely as ‘injury’; thus, less than half a century ago, the definition consisted of one line all told.

Twenty years later, the dictionary also recognized a ‘psychological trauma’ and an adjective ‘traumatic’. And in 1984, when the psychological variant had expanded the entry for ‘trauma’ to thirteen lines, it also mentioned ‘sexual trauma’ and the adjective ‘posttraumatic’, and the verb ‘traumatize’ (with reference to ‘shock’) made its appearance. Regarding the concept of ‘stress’, whereas the edition of 1956 did not yet include this word, by 1984 the Dutch language recognized not only ‘stress’ but also various extensions of the word: ‘stressor’, ‘stress situation’, and ‘stress phenomena’. The same edition included another new concept, ‘(post-) concentration camp syndrome’.

In light of these facts, one wonders if they are evidence of growing medical insight or if they merely illustrate that even medical science is subject to trends and the fashion of the times. One thing is certain: PTSD, as a combination of the above terms, has proliferated widely – particularly in the media and among the general public – since 1980 when it was incorporated into the DSM. Expressions such as trauma, (post-) traumatic stress, and ‘coming to terms’ have rapidly become part of our everyday vocabulary – and of the necessities of life. There is no emergency – large or small – without a psychotrauma team rushing to the scene and, in TV interviews, unabashedly predicting what kinds of problems the victims will develop. It is as if PTSD were a disease that you cannot avoid getting if you experience something ‘bad’ and do not get immediate psychotherapy. Also this pattern makes one wonder. Does it represent belated recognition of the widespread suffering that has existed for years as an unnamed, unseen, and untreated disease? Or is it a contagious fashion, a goldmine for enterprising new professions to exploit?

Summerfield: PTSD is not a disease

The Internet debate about Summerfield actually did run more or less along these lines. In a brief, thought-provoking article, he had argued that although PTSD is nowadays considered
to be a ‘disease’, it really isn’t one. He argued that diseases exist independently of our consciousness and our observation. This was demonstrated by the discovery of sepsis as well as AIDS, for instance. Long before anyone had even suspected their existence, let alone given them a name, these deadly bacteria and viruses were at large and killing people – until one day the evildoers were ‘discovered’. PTSD does not exist as that kind of ‘objective’ phenomenon, one that is present outside our body of knowledge. In the case of PTSD, there was no ‘discovery’ of a ‘natural entity’. PTSD was a human invention; with the introduction of this concept, a series of frequently occurring yet highly diverse symptoms could be neatly placed in a single category. Thus it was labeled, though without, as for a disease, saying anything about the course it would take.

With regard to the term ‘invention’, Summerfield cites Shephard almost verbatim in his own conclusion; Shephard (whose work is discussed below) stated concisely and to the point that PTSD is just as much a political as a medical invention. Both Summerfield and Shephard based their conclusions on the struggle by Vietnam veterans to gain recognition of PTSD and to get this ‘disease’ adopted by the DSM.

Inclusion in the DSM subsequently sets a new dynamic in motion. People will be diagnosed as suffering from PTSD; therapists will appear who specialize in this field (psychotrauma therapists), specialized hospitals will emerge, along with specialized journals and associations, brochures, standards, congresses, and information for other physicians besides psychiatrists. The public becomes acquainted with the term and people start applying it to themselves or others. All of this has evidently occurred for both ‘trauma’ and PTSD. In the Netherlands, for example, it became common practice for specialized caregivers and institutions to help people who had been involved in an accident, had been threatened, or had experienced some kind of disaster. Summerfield refers to this as a ‘trauma industry’. Previously, I introduced the related terms of ‘war industry’ and ‘trauma culture’. Shephard speaks of a ‘culture of trauma’.

However, charting the unmistakable course of these proliferation processes does not necessarily mean that there is anything wrong with either the idea or the diagnosis ‘PTSD’ itself. In that regard, Summerfield rightly refers to the etiology suggested by this terminology. (It is with respect to etiology that PTSD differs from the other diseases listed in the DSM, where nothing is said about the cause of such illnesses.) Clearly, the term posttraumatic implies that something happened AFTER and BECAUSE OF the traumatic event. The trauma is the origin of the disease. That is essential. In my research, I analyzed articles on the topic of war trauma published in the Dutch mental health journal *Maandblad Geestelijke volksgezondheid*. I wanted to find out for which dilemmas a solution was being sought in the recognition and nomenclature of ‘war trauma’. My findings were the same as those of Shephard and Summerfield. Briefly, the Dutch struggle to gain recognition for the concentration camp syndrome (which was, incidentally, a struggle waged more by physicians than by patients) and the effort of the Vietnam veterans had the same thrust. Besides asking for financial compensation, both groups demanded an acknowledgement that the problems, although ‘psychological’, did not lie ‘within’ the individual. They wanted it to be recognized that the cause was not a difficult childhood, marital problems, or a weak character, but rather an ‘external stressor’. I will return to this important point later.

Summerfield’s proposition that PTSD does not exist was challenged in no uncertain terms. The website filled up with messages from patients setting forth their symptoms and
therapists who invited Summerfield to come and see for himself what was going on in their office. Their responses would fill half a book; here are a few examples.

A medical archivist, who characterized the article in BMJ as ‘insulting’ and accused Summerfield of showing a lack of respect for his patients, pointed out that members of the Dutch Resistance and Jewish survivors of the Holocaust certainly do have more problems than the ‘normal suffering’ that Summerfield claims people can no longer cope with nowadays.

A Gulf War veteran considered Summerfield’s article to be both inaccurate and insulting. He says, “I did not ask to suffer from intrusive thoughts, flashbacks, nightmares, and all the other myriad of symptoms connected with PTSD (I expect none of the other veterans did either).”

A lawyer pointed out that before PTSD was recognized, thousands of patients were diagnosed with schizophrenia and were consequently inappropriately treated, given the wrong medication and committed to institutions, amounting to a repetition of the traumatic experiences. Summerfield is said to be “adding insult to what is for many, a very, very real injury.”

Finally, as Arieh Shalev, the renowned Israeli psychiatrist, sarcastically remarked, “Encouraged by Summerfield’s revelation about post-traumatic stress disorder, I imagined myself going to my clinic the next day and, at last, telling my post-traumatic stress disorder patients that their disorder is but a social invention. I also thought that I would apologize, admitting I was wrong in choosing to diagnose their problem and thereby medicalize their condition instead of seeing it as normal human suffering.”

All these angry people are right. And so is Summerfield, at least to some extent. While the concept of PTSD may indeed be a ‘social construction’ – an agreement to systematize a set of diverse symptoms – of course there are traumatized persons with severe problems that need treatment.

Shephard: the century of war trauma
Perhaps Summerfield’s article is indeed, as one of his colleagues wrote to him by way of the Internet, a typical case of ‘good intention, poor method, bad outcome’. The doctor is dabbling in social science and throws out the baby with the bathwater because he is thinking in dichotomies: PTSD is either a disease or it does not exist, either real or fashion, either medical or social.

Fortunately, there is another way to look at the intriguing phenomenon of mass afflictions that sprout up only to disappear again. More fruitful than these dead-end dichotomies is a historical-sociological approach that takes these psychological disorders seriously.

A case in point is the analysis by Ben Shephard, an English historian, who had previously compiled several widely discussed documentaries on World War II for the BBC. He carried out an extensive and probing study of how the field of military psychiatry has developed since the end of the nineteenth century. His book, entitled A War of Nerves, is focused on England and the United States. In the following section, I compare his findings with the situation in the Netherlands. I do so on the grounds of my own research on how the Maandblad Geestelijke volksgezondheid presented ‘the war’ in the period 1945-2000.
It was specifically through the concept of war trauma that the word ‘trauma’, in its psychological sense, found its way into our collective body of knowledge. If the nineteenth century was the century of hysteria and neurasthenia, the twentieth was the century of war trauma. Shephard delves anecdotes from an overwhelming amount of material – from novels and poetry, medical reference books, psychiatric congresses, diaries kept by patients, letters from soldiers, recollections of therapists, government reports, statistics, and newspaper articles – to give a picture of the period. He sketches the medical debates and dilemmas concerning the soldiers who broke down on the front and the veterans who became disturbed afterwards, while he also depicts the social and cultural context in which these debates took place.

The blade that the author uses to slash his way through this diverse undergrowth is the contradiction between a tough and a tender approach to psychological trauma. Some doctors, whom he calls ‘realists’, were out to cure the patients by whatever means they could. In contrast, the type of therapists he calls ‘dramaturges’ were primarily interested in the meaning of the symptoms – the idea was that recovery would come from understanding on the part of the therapists combined with insight on the part of the patients in the connection between their wartime past and their symptoms. According to Shephard, the two poles of tough and tender may be discerned in every one of the countless theories and treatments of war neurosis that the twentieth century has seen.

Shell shock
What were the main diagnostic epochs leading up to the current Realm of PTSD?

At the end of the nineteenth century, an affliction called soldier’s heart was already known in America. This wistful name was used to describe the aftereffects in the form of all manner of vague symptoms that soldiers sometimes had in the aftermath of the Civil War. A problem inextricably linked with the First World War is the epidemic of shell shock. Doctors quickly discovered that some of the soldiers who suffered from shell shock had not been anywhere near an exploding grenade. Even men with nerves of steel had been transformed by having to wait helplessly for death to descend arbitrarily upon them, without ever having seen the enemy; they turned into trembling wrecks tormented by nightmares. The ‘management of fear’ was to become one of the main themes of the Great War literature. But initially, symptoms such as deafness, dumbness, blindness, amnesia, strange physical contortions and compulsive movements, exhaustion, and overall maladjustment (also diagnosed as the disease GOK, God Only Knows) were not considered psychological phenomena but the effect of shrapnel, air pressure, noise, or poison.

Thus, the designation ‘shell shock’ proved to be inadequate nomenclature. Nonetheless, the term took on a life of its own – just as PTSD has recently done. Shephard calls it a harpoon concept; just try to extract it once it has become lodged. Shell shock offered an option for a comfortable compromise. It had now been proven that you did not have to be either a cowardly ‘unmanly’ deserter or a degenerate crazy to become mentally disturbed by wartime experiences. Furthermore, the fact that many of the shock patients were officers made its acceptance easier. Nonetheless, under the harsh regimen in the British armed forces, which did not want to lose any ‘healthy’ soldiers by allowing doctors to be too soft, many of those suffering from shell shock were executed on the front. Often, patients who were less interesting than the famous war poets Owen and Sassoon were just put away in old-fashioned asylums.
Anyone who has read Pat Barker's phenomenal fictional trilogy, *Regeneration*, is acquainted with Sassoon's humane physician and colonel, Dr. William Rivers, a pioneer in methods of treatment inspired by Freud. The military establishment refused to consider any treatment that leaned toward 'sentimental introspection', contrary as it was to the stiff-upper-lip masculinity that prevailed at the time. Nonetheless, Shephard criticizes Barker's infectious empathy for Rivers, calling it a product of seventies feminism, and sides a bit with his opponents. According to Shephard, sometimes the Kaufmann treatment, which was common prior to Rivers, actually did produce results. Indeed, Shephard states that electrical shock therapy sometimes cured conversion phenomena such as dumbness and paralysis, at least temporarily. However, in Rivers' view (and Barker's too), this course of treatment was a form of abuse.

The ergotherapy (therapy through structured work) prescribed by Owen's doctor, who believed firmly in the effects of work, discipline, brisk walks, and ice-cold baths, was indisputably successful. Incidentally, so was immediate treatment on the front with rest, caring attention, and exercises.

Freud referred to his military colleagues as 'machine guns behind the front lines'. One of the main themes in Shephard's work is the great dilemma of military psychiatry, namely that curing a patient usually killed him, because he had to go right back to the front. After all, whose interest was being served by the military psychiatrists – that of the army or that of the soldier? Freud's answer was plain and simple: the army's. In time of war, it could be advantageous to be declared insane. What makes the case of Sassoon so interesting is that this poet was opposed to the war on political grounds but nonetheless wanted to return to his troops. He did not want to be a coward and refused to escape their fate through insanity. (Unlike Owen, Sassoon survived.)

This brings us to a second question that keeps reappearing throughout the entire twentieth century with regard to 'traumatic neurosis': the possible 'secondary gain'. Sometimes, being labeled as 'sick' offers advantages that hamper recovery, such as attention or exemption from duty. According to Shephard, statistics show that symptoms often disappeared as soon as a patient knew that he did not have to go back to the trenches. This does not make the disorder mere affectation, but it does raise the question of whether pensions, benefits, and exemptions are really in the patients' best interests.

Conversely, Shephard also cites gripping stories of people who came through a dangerous situation in good shape but years later developed distressing – psychogenic – symptoms. In the Netherlands, this phenomenon is found among survivors of concentration camps. Unfortunately, the medical insights that had been derived from the First World War were not recorded in medicine's collective memory. Shephard points out that at the end of World War One, the medical establishment knew quite precisely what kind of conditions could engender the feared affliction of shell shock in which kind of groups. However – and here his indignation is echoed in the text – that knowledge was lost. For instance, in 1918, it was clear that the risk of affliction was higher in a bad, undisciplined, and uncomradely company. Moreover, the kind of person one was before the traumatic experience (the premorbid personality) was found to make a difference. In 1940, though, the prevailing

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notion among physicians was that a gentle approach generates ‘benefit neuroses’ – the costs of World War One still weighed heavily on the British budget.

**World War Two and Vietnam**

Another kind of war with battles of a different kind produces another kind of patient. The patients suffering from combat or battle fatigue, as the war disease of 1940-1945 was called, were not the chronically ill soldiers described in the shell-shock literature. Rather, they were soldiers who had had a nervous breakdown after seeing action and had to be put back on their feet quickly. Psychopharmaceuticals and experiments with on-site cognitive, behavioral, and directive group therapy (the aversion to introspection was still strong in the military) were fairly successful. Indeed, they contributed to later developments in medical psychology. Yet the fact that the veterans of World War Two adjusted so well in peacetime was due primarily to the warm welcome they received when they got home. The heroes of the Good War were given priority in employment. The women who had to make way for them in the workplace were sent home with the advice to pamper their men – and they did just that. In 1950s America, men were treated like kings and sons like princes.⁷ The victorious mood of heroism and success formed a shrill contrast to the cool reception given to the Dutch war victims, who came back to a nation in a mood of discipline and asceticism. The contrast was also shrill with respect to the third war that has shaped thought about trauma, the Vietnam War, to which we owe the now predominant concept of PTSD.

The current standard model of how people react to a disaster – PTSD – is actually based on a specific situation. It reflects the experience of soldiers coming back from a controversial war – one that had been lost and was extremely cruel – to a society in which self-discipline and responsibility were no longer collective values. While in 1940 it had been ‘normal’ for men and boys to give their lives for the fatherland, by 1970 this value was a thing of the past. Moreover, Vietnam was not a ‘good war’ like the one fought by the Allies against Nazi Germany and Japan. Vietnam was no war to come home from feeling proud. This made the returning soldiers lonely and deepened their sense of guilt. Something we had learned from the First World War was that it was helpful if soldiers felt they had a say in their fate. A sense of futility, in contrast, meant a poor prognosis; a high likelihood of what we now call PTSD. (With respect to the perception of the sacrifices demanded of them as pointless, meaningless, and involuntary, a comparison with the Dutch situation – the wars of decolonization in the Dutch East Indies and the ensuing repatriation – might be fruitful.)

The image that Shephard paints of developments after 1970 is disconcerting to say the least. As noted earlier, he says that PTSD is as much a political as a medical invention. While still in ‘Nam’, the soldiers did not develop any major medical or psychological problems. To help them press on with their exacting anti-guerrilla effort, they were given ample rest, recreation, and the new benzodiazepine drugs to keep them going. Indeed, Vietnam was a war in which little actual fighting took place. After a raid, the soldiers returned to their base camps, where they were provided with all manner of little pleasures. Once back in America for good, however, they proved unable to pick up where they had left off. Unemployment, alcohol, drugs, violence, murder, and suicide were frequent among the ones who came home. Often, their wives or girlfriends had not waited for them or had

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turned into anti-war activists (as in the movie *Coming Home* starring Jane Fonda and Jon Voight, which was felt to be a deeply moving film at the time). Well-meaning psychiatrists stood up for the veterans, often motivated by a general anti-war attitude. As a result of the concerted lobby of veterans and therapists, PTSD was included in the diagnostic manual of psychiatric disorders. Now it was established that 'normal' persons can develop a psychiatric disorder from abnormal experiences. This recognition was advantageous at the time but, according to Shephard, eventually proved detrimental. The problem was not a lack of funds or good intentions but the absence of effective methods of treatment. The lessons of 1918 and 1945 had been forgotten, as Shephard does not tire of repeating. One of these lessons was to give immediate treatment and to focus that treatment on getting back to work and normalcy. Fighting for recognition of a 'disease' that nobody knew how to cure, says Shephard, created an army of chronically ill, chronically complaining veterans. They were often out of work, sometimes violent, and mostly addicted to drink, drugs, and the dole, as well as to a newly created identity – the identity of a ‘trauma victim’. Furthermore, this pseudo-success was adopted as a model by other organized victim groups that were claiming their right to ‘recognition’. After the initial negligence of the veteran issue, the tender pole gained ground from the tough approach, though at the expense of the goal of helping people get back to normal and take part in society again.

**The Netherlands**

Reading Shephard’s account of how the notion of trauma has evolved in England and the United States, comparison with the situation in the Netherlands seems pertinent. What was going on here? Before 1945, we had not been to war for a century; we had been spared the military violence of the First World War and, though involved in the Second, the casualties were not primarily victims of *military* action. So does the fact that the Netherlands had no World War One mean that we had no shell shock? Does the absence of large-scale military operations mean there was no combat fatigue? Does no Vietnam War mean no PTSD? Actually not. Moreover, the mental consequences of ‘our’ history of war trauma (even though it did not begin till after 1945, and then with the concentration camp syndrome instead of with shell shock and combat fatigue) are strikingly similar to those in the Anglo-Saxon countries. In our country too, the recent expansion of knowledge about war trauma has led to the emergence of a trauma culture.

Though often assumed otherwise, immediately after liberation, professionals in the field of mental health were certainly aware of the psychological damage that a period of internment could cause, even in the long run. At the same time, in those years of ‘discipline and asceticism’, as the historian Blom typified the early postwar mood, there was a general fear that too much attention would only encourage individuals to indulge in their ‘neurotic maladjustment’. A major argument was based on the notion of ‘benefit neurosis’, which had been the subject of debate with respect to health insurance. In itself, insight into the notions of ‘benefit neurosis’ (in a psychoanalytical sense) or ‘secondary gain’ (in a sociological sense) was enlightening. It shed light on the reasons why people will sometimes rather remain ill – for example, because it is too hard to live with the responsibilities of a healthy person. Thus, the notions of ‘secondary gain' and 'benefit neurosis' describe internal mechanisms that are quite different from deriving an advantage from mere malingering – for one thing, the degree to which the patient is aware of such
motives is different. It is in the interest of the patients to counteract the invalidation that comes of being declared sick and thereby eligible for disability benefits. Unfortunately, however, these useful notions were mainly applied in a distrustful and patronizing manner, as if the individuals so labeled were indeed just pretending.

In the Netherlands, for a long time, another useful notion had been wielded as a weapon against those who had been traumatized by war, namely the notion of the premorbid personality. This refers to the personality of the patient before he or she experienced the trauma. For instance, when people who had been in the Dutch Resistance applied for a pension, the review procedures led to indelicately worded disputes over whether the psychological handicaps had ‘really’ come from the war or whether the person had already been in a feeble state of mind before then. Around 1970, progressive doctors argued that previous personality traits were irrelevant; internment in a concentration camp, regardless of the kind of person one had been beforehand, had to count as the cause of subsequent problems. Otherwise, requiring the applicants to submit to a psychological assessment would be tantamount to repeating what they had been forced to endure under persecution or in the Resistance.\(^8\) Because of the bluntness of the medical examinations, this topic – like thoughts on the notion of ‘secondary gain’ – became taboo. That is too bad because, as also Shephard’s material about shell shock demonstrates, the victim’s personality is certainly one of the variables determining how much of a chance a person has to recover after a disaster.

The concern with war damage was replaced in the 1950s and 1960s by a mood of ‘discipline and asceticism’. Mirroring the prevailing mood in Dutch society as a whole, from about 1950 on, little was said about the wartime past in the mental-health journal *Maandblad Geestelijke volksgezondheid* – which gives a good picture of developments in this sector – until the late 1960s. A turning point came in 1972 when Parliament debated the impending release from prison of three German war criminals serving life sentences in the penitentiary at Breda. This was one of the first occasions at which psychological suffering was brought to the attention of the public and had some bearing on political standpoints. From then on, the term trauma has played a prominent role in the way we think about everyday events. From then on, too, more and more groups have come forward claiming to be traumatized. First there were the persecuted Jews and former members of the Resistance; then came persons who had been held in Japanese concentration camps in the Dutch East Indies; then the youngest generation of those internees known as ‘camp children’; then the ‘civilian war victims’; the children of Jewish survivors; people whose parents had been in the Resistance; and the offspring of members of the Dutch National Socialist Party, which was affiliated with the Nazis.

In the meantime – with the clarity of hindsight – we can see that the ‘recognition’ of what some Dutch people had endured in the years 1940-1945 was fostered by the discovery of the ‘late sequelae’ and has been linked to ‘being sick’. Thus, the benefit (recognition of the fact that traumatic experiences can lead to long-lasting or late-manifesting problems)

\(^8\) Extensive material dealing specifically with the Resistance and the medical examination required for a special pension is found in the sensitive writings of the psychiatrist Hugenholtz. See Withuis, ‘Erkenning’ for a description of his work in the context of the history of war trauma.
was implicitly detrimental: the recognition of people’s harsh or heroic wartime past was linked to the status of victim.

**Latent functions of the PTSD concept**

In this regard, it is enlightening to analyze which functions certain concepts have served. Since 1945, people have been searching for a word that covers the problems of the survivors. The terms ‘KZ syndrome’ and ‘post-concentration camp syndrome’ were in use around 1970. Yet these words seemed to exclude members of the former Resistance and people who went into hiding, whereas they often had all kinds of severe symptoms – just like the survivors of the concentration camps. The explanation for their problems was that they too had lived in mortal fear for a long period. Thus, it was necessary to expand the conceptual apparatus. A second ‘requirement’ was that it had to be clear that even individuals who had previously been able to function well and were psychologically robust could also be damaged by traumatic experiences. It had to be made clear that people suffering from KZ syndrome had not already been weak souls. Thus, the disorder needed a name that would emphasize the causal significance of the ‘external stressor’. And thirdly, there was widespread (and, in Resistance circles, strong) aversion to illness in general and mental illness in particular. In this vein, a physician specialized in internal medicine, Dr. Hers – himself a member of the Resistance and a concentration-camp survivor – told a story about a patient who, upon hearing that he had an inoperable tumor, responded by saying, “Fortunately I don’t have KZ syndrome and I’m really sick.”\(^9\) It was important for a disease to be recognized as such. On the one hand, recognition induced people to admit that they had psychological or psychogenetic problems; on the other hand, it made doctors and insurers realize that late or long-lasting manifestations really did exist. After various terms had made the rounds, PTSD was eventually found to meet all of these needs. Thus, from the mid-1980s on, the concept became more and more common. Not everybody was happy with it, though. The psychiatrist Eddy de Wind – well known from way back as an advocate of acknowledging the deplorable situation of the Jewish survivors – felt it was an insult, that the use of this term implicitly equated surviving Auschwitz with experiencing distressing events like an automobile accident or a robbery. In PTSD, the avowal of the external stressor went hand in hand with the disavowal of the unparalleled nature of the Holocaust.

These events were indeed equated, even before the term PTSD became generally accepted. The more accepted the war syndrome became, the more commonplace was the opinion that if people did not express their feelings about ‘traumatic events’ and try to come to terms with these, they might develop problems that would be long-lasting or could become severe in the long run. Evidence to back this up was also provided by new and shocking insights based on research into incest, among other things.\(^10\) The term trauma was expanded to cover incidents of robbery, bad news, loss of loved ones, natural disasters,\(^9\) J.F. Ph. Hers, ‘Leven met en in de schaduw van het oorlogsverleden’ [Living with and in the shadow of the wartime past], in *Nederlands Tijdschrift voor Geneeskunde*, vol. 129 (1985) 18, pp. 820-823. The story is set in 1966.

\(^{10}\) See Nel Draijer, *Seksuele traumatisering in de jeugd. Gevolgen op lange termijn van seksueel misbruik van meisjes door verwanten* [Sexual traumatization during youth. Long-term consequences of sexual abuse of girls by relatives], Amsterdam: SUA, 1990.
automobile accidents, and even losing one's job. In addition, terms such as ‘secondary’ and ‘transgenerational’ traumatization were coined.

A diagnosis of PTSD is based on several criteria: continuously reexperiencing the event (through nightmares or flashbacks, for instance); persistent avoidance of stimuli associated with the trauma (not having the TV on if German can be heard) or even complete numbing; and a persistently increased arousal, resulting in sleeplessness, for example. To qualify for a diagnosis of PTSD, a person would have to suffer from a number of these problems; moreover, these manifestations would have to persist for more than a month.

Besides these problems, the diagnosis calls for a demonstrable ‘traumatic experience’. Though this would seem to be obvious, it is actually the trickiest part of the definition. The point is, how do we know what constitutes a ‘traumatic’ experience? We usually think of rape or a brush with death, but subjective (both in a personal and a sociocultural sense) factors play a major role in how a ‘trauma’ is experienced. What constitutes an unbearable shock or amount of tension for one person under certain circumstances will be fairly easy for another to cope with. In consecutive versions of the DSM, we see that the compilers have also grappled with this problem. Initially, trauma was described as an event that is outside the range of usual human experience, and that would be markedly distressing to almost anyone; this phrase was left out of a later version, DSM-IV (1994).

On the other hand, the concept of trauma has continually been expanded in practice, even to the point of becoming trivialized. All in all, it has more or less become a diagnosis that can be proven after the fact. You become traumatized by event X, and X constitutes a trauma because you turn out to have been traumatized by it – a clear case of circular reasoning.

Can anything be done about this? Is there anything wrong with it? To answer the first question, I don't think so. It is a fact of life that people differ with respect to how much they can bear. Thus, one and the same event may be a trauma for one person while for another it will be a hardship that he or she will eventually overcome. To me, it would seem appropriate to try to build this element of relativity into the DSM; that is, some events should not be excluded outright as possible sources of trauma. How bad something is depends much less than we tend to think on the objective severity of an event and much more on who it happens to and the context in which he/she has to experience it.

That said – and this is my answer to the second question – we still have to maintain a critical attitude.

Trauma culture

A critical attitude is precisely what has been lacking. Between 1945 and 1975, the mentality of the Dutch population underwent a transformation. The emotions were emancipated and the ‘culture of silence’ of the postwar reconstruction turned into the ‘culture of speaking out’ of the 1970s and 1980s and subsequently into the ‘trauma culture’ of today. Around 1970, it was still very difficult for survivors of the Second World War to face up to their psychological problems – merely acknowledging their existence would mean that Hitler had won after all – but nowadays sickness is no longer taboo. After decades of underestimating the extent of the problem, that shift – in all its tenderness – was a welcome development (as was the official recognition of PTSD), though, as we have learned in the meantime, it also has a downside. In the Netherlands, as elsewhere, PTSD is taking on epidemic proportions and chronic victims exist. Here
too, ‘trauma’ has become associated with special-interest groups, while assertive spokespersons, mediators, and organizations that exist by virtue of the war sector play a prominent role. And here too, the notion of trauma has lost some of its meaning.

In 1995, some Dutch regions were overwhelmed by the threat of flooding, but the river dykes held back the rising waters. A ‘psychotrauma’ team was on standby during the quasi-catastrophe to help evacuees cope with the trauma of a defrosted freezer. A few years later, a marathon in Amsterdam ended abruptly in a tunnel with a massive pile-up of in-line skaters – the most assertive of all road-users. “They led us like sheep to the slaughter,” was their comment, and they quickly hired lawyers to press claims for damages. And some Dutch vacationers who had survived an avalanche that had taken the lives of other skiers said, “We went through hell, but the Netherlands didn’t send professional support.” A more fitting response might have been, How lucky we were! Then, in 2000, when the Emperor of Japan apologized for the occupation of the Dutch East Indies during the Second World War, the survivors’ response was, “Saying sorry without offering money doesn’t count.” Then too, Tara Singh Varma explained her elaborate deceit on the grounds of a posttraumatic stress disorder; some years back, she had referred to her financial fiddling in a charity committee as a ‘trauma’ – to herself, that is.

This mental transformation brings us back to the position taken by Summerfield. He believes that people are no longer capable of accepting ‘normal human suffering’ and sorrow as something that is part of life. What happened to the stiff upper lip – the mentality that sent the boys to the front and ensured that after they had fallen for the sake of their fatherland their next of kin got on with life and did not complain? That has indeed disappeared. As we have been able to observe after Dutch peacekeeping missions, that kind of self-sacrificing mentality no longer exists. Also Shephard, in his much more subtle analysis, makes a link to the changes in mentality that occurred between roughly 1945 and 1975. My own literature study (of Maandblad Geestelijke volksgezondheid) points in the same direction.

What has turned the victim role into a ‘culture of complaint’? The notion that ‘being tough’ and staying silent is the wrong recipe was reinforced by the democratization and assertiveness of those same years. The timid victim turned into a whining citizen who demands happiness – an articulate claimant of compensation. Being sick changed from something to be ashamed of into something some groups consider to be an appealing attribute. This is particularly true for the concept of ‘trauma’. That is why I have introduced the term ‘trauma culture’, inspired by the Dutch sociologist J.A.A. van Doorn, who recently described his observations on all kinds of claims by referring to a ‘culture of complaint’ and ‘victimitis’.

It would go beyond the scope of the present article to delve into the background of this development in the Netherlands. Moreover, this topic warrants much more research than has been carried out so far. One thing is clear, though: posttraumatic stress disorder has a strong cultural component. We do not want to follow Summerfield’s example and throw the new knowledge about PTSD overboard. Yet we do advise giving due consideration to all the points that have been raised by him, by Shephard and by myself as well as by others – particularly those involved in care for political refugees. Being subjected to and coming to terms with threatening events is influenced by several factors: the victim’s personality and culture; the affective, cultural, and social context to
which he or she returns; the reception and social support he or she receives; the perceptions of how ‘normal’ that experience is; and so on. Research should focus on issues such as ‘secondary gain’ and the ‘premorbid personality’; these notions should be brought out into the open for frank discussion. And we should liberate ourselves from the pitfall of concretism. We would be making a dangerous conceptual error to suppose that the vague and varied problems that characterize PTSD and its predecessors constitute a closely circumscribed disease that a person must get after a shocking experience. As the doctors at the front already knew in 1914 and 1940, not everyone becomes traumatized by a disaster.

Shephard concludes that it is not a question of tender or tough but that a dialogue between these two poles should influence the medical and social attitudes toward afflictions such as neurasthenia, shell shock, combat fatigue, and PTSD. Besides offering understanding and help in finding meaning, the goal should be to treat the problems and integrate the afflicted again in normal life with its normal range of responsibilities. Most of all, we should guard against the invalidating tendency to turn the victim role into a social identity. We should not lose sight of what has been gained: that recognition (by the victims themselves and by those close to them) of the suffering would end the psychological fixation on the past so that the individuals, liberated to some degree, could once again take control of their lives and go on to develop an identity other than that of a victim.

The rise of ‘victimitisation’ provokes aversion and cynicism. This might mean that we would again start telling victims they should stop whining. If so, then the over-assertive pseudo-victims will have spoiled things for the real ones, who in fact usually suffer in silence.

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