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When warriors break: combat's dark legacy

What we have learned since the American Civil War (1861-65), notes psychologist Simon Wessely, is that every major armed conflict produces a unique variety of psychological casualties. British medical researcher Edgar Jones and his colleagues contend that war-related psychological symptoms (as well as the physical manifestations of these symptoms) are influenced by contemporary medical knowledge, changes in the nature of warfare, and underlying cultural forces. To this list I would add existing military and political structures and the dynamics of these structures.

During the Civil War, soldiers suffered from "soldier's heart" or Da Costa's Syndrome (named after Dr. Jacob Mendes da Costa who investigated this disorder both during and after the

war). Manifestations of soldier's heart included fatigue, shortness of breath, sweating, chest pain,

and heart palpitations. These symptoms typically persisted even though examining physicians could not detect any physical abnormalities. At a loss to accurately explain much less treat these

symptoms, military physicians simply rid the army of problem soldiers. In his book "No More Heroes: Madness and Psychiatry in War," Richard Gabriel notes that many of these men "were put on trains with no supervision, the name of their home town or state pinned to their tunics, others were left to wander about the countryside until they died of exposure or starvation." According to Gabriel, the growing number of afflicted soldiers wandering about triggered a public outcry that resulted in the first military hospital for the insane in 1863. This institution was closed at the conclusion of the war two years later.

An early explanation for soldier's heart was nostalgia, the yearning for home, family, and the familiar rhythm of life. Afflicted soldiers were considered nothing more than duty-shirking malingerers. In 1864, the assistant surgeon general stated: "It is by lack of discipline, confidence, and respect that many a young soldier has become discouraged and made to feel the bitter pangs of homesickness, which is the precursor to more serious ailments." From this perspective the real problem had little to do with the war. Rather, it was the soft-heartedness of men unwilling to meet their military obligations.

With significant advances in destructive weapons in the latter half of the 19th and early 20th centuries, World War I (1914-18) is often called the first modern war. Hunkered down in trenches, soldiers in all armies endured frequent and prolonged artillery barrages and mortar attacks. British physicians coined the term "shell shock" to describe the dazed, disoriented, and withdrawn condition that afflicted an increasing number of troops. Doctors attributed this condition to physiological damage to the brain sustained by exploding shells.

However, physicians discovered that soldiers not close enough to the shelling to suffer physical injuries exhibited many of same psychological

symptoms as their wounded comrades. Just as in the Civil War, military leaders and many physicians believed these soldiers were attempting to shirk their duty. They were malingerers if not outright cowards as well-adjusted, brave men could withstand the rigors of combat with little risk of breaking down. The British Army executed 306 men during the war for a variety of reasons including "cowardice" and "refusing to fight." Military historians note that an undetermined number of these men were likely suffering from shell-shock and shot after mock trials as a "lesson to others."

Based on his own front-line observations and the growing number of shell shock casualties (in some units up to 40 percent of all casualties), British Army Captain C.S Myers, a specialist in psychological medicine, advanced a psychological, prolonged high-stress explanation for the shell shock condition. British Psychiatrist Derek Summerfield states that Myers's perspective gained favor in the army for two reasons. First, in the midst of an expanding war, the army would not have to deal with tens of thousands of disciplinary cases implicit in the malingering and cowardice interpretation. Second, any explanation that allowed for the eventual return of shell shocked troops to the front lines (after their damaged psyches were repaired) in a high casualty war was desirable.

Sociologist Wilbur Scott states this explanation and strategy was followed by the U.S. Army as well. A psychiatrist was assigned to each U.S. division to treat soldiers as quickly and as close to the front lines as possible. "Treatment consisted of several days of creature comforts and the firm expectation that a soldier would return to duty." This rest and recuperation treatment was considered a success as almost two-thirds of afflicted soldiers returned to the battlefield. Psychologist Edgar Jones and his colleagues state that by the end of World War I some physicians believed physical and psychological injury symptoms overlapped and it was difficult to distinguish the effects of a mild head injury from those of an exceptionally stressful experience.

Psychiatrist Peter Howorth argues that as the war dragged on and casualties (including shell-shock) mounted, many British soldiers came to view the conflict as senseless. "They despised the warmongers at home," Howorth states, "more than they hated the Germans, and felt alienated from the civilian world." One can imagine the adjustment problems these men – especially those who also suffered from shell-shock – endured upon returning to their families.

Beginning in 1940 the U.S. military embarked on a plan to identify inductees who might be predisposed to emotional battlefield problems. During the course of World War II draft boards would eventually determine that almost 1 million young men were psychologically unfit to serve. Because psychiatric tests were designed to screen out individuals likely to breakdown, the problem of what would eventually be called "combat fatigue" was thought to be largely solved.

In 1943, Navy Commander Edwin Smith reported on his treatment of over 500 Marines who were suffering from a condition he described as "Guadalcanal Neurosis." As a consequence of prolonged and particularly savage fighting on the Pacific Ocean island of Guadalcanal, these men had broken down emotionally. Among a long list of symptoms, they suffered

from headaches, periods of amnesia, tremors, and "wept easily." Smith believed the condition of these Marines was a "disturbance of the whole organism, a disorder of thinking and living, of even wanting to live." Smith stated that no screening tests at recruiting stations or boot camp could indicate the psychological problems these men would experience in combat.

With mounting evidence that battle hardened veterans from the nation's elite Army and Marine Corps units were susceptible to various manifestations of combat exhaustion, the military halted the psychiatric screening of inductees in 1944. The reality among commanders that any individual could crack after prolonged combat began to take hold

One in four World War II casualties was caused by "combat fatigue," one in two among men who had experienced prolonged, intense fighting. The 82-day-long battle of Okinawa (1945) involved four Army and two Marine divisions (along with troops from other allied nations). Over 14,000 American soldiers, sailors, and Marines died. There were approximately 26,000 cases of combat fatigue, the greatest number of the war in a single campaign.

"Let Their Be Light," a 1946 documentary funded by the U.S. Army followed 75 "psycho-neurotic" soldiers being treated in military hospitals. The narrator states that "Every man has his breaking point...and these were forced beyond the limit of their endurance." Upon review, the Pentagon banned the film. It was declassified in 1980. ***The Making of PTSD***

Sociologist and Vietnam War combat veteran Wilbur Scott describes how post-traumatic stress disorder (PTSD) came to be an official psychiatric disorder listed in the America Psychiatric Association's (APA) "Diagnostic and Statistical Manual" third edition (DSM-III) published in 1980.

A faculty member at the U.S. Air Force Academy, Scott notes this story is important for two reasons. First, it raises the question of "what constitutes the normal experience and response of soldiers to warfare." What psychiatrists once considered abnormal behavior would come to be viewed as a "normal" response to combat. That is, to be traumatized by combat was a normal human reaction to an abnormal situation: the horrors of war. Second, the story illustrates "the politics of diagnosis and disease." The making of PTSD is a clear example of how medical scientists and their allies successfully advanced a psychiatric diagnosis as both an accurate description of reality and a discovery of a condition that was real (PTSD) but previously unknown.

Published in 1968, the DSM-II omitted "gross stress reaction" (which appeared in the DSM-I published in 1952), a disorder produced as a consequence of serving in combat. Scott argues that a likely explanation for dropping gross stress reaction was that individuals revising the DSM-II had no direct experience in World War II and/or the Korean War. Also, respected psychiatrists serving in Vietnam were of the opinion that existing disorders in the DSM-I covered the range of emotional problems experienced by soldiers fighting in Southeast Asia.

In 1967 a small group of Vietnam War veterans gathered in New York City to protest a war they considered unjust. Taking the name Vietnam Veterans Against the War (VVAW) they urged fellow veterans to help end

the conflict and bring their "brothers" home. The VVAW would play a key role in placing PTSD in the DSM-III.

Scott notes that as the war unfolded many Veterans Administration (VA) physicians believed that veterans who were agitated by their wartime experience suffered from some neurosis or psychosis whose origin "lay outside the realm of combat," that is, a pre-existing condition. Not all psychiatrists shared this perspective. Upon reading of the My Lai Massacre in Vietnam (1969) where U.S. Army soldiers killed between 347 and 504 unarmed civilians, psychiatrist Robert Lifton (who served as a military psychiatrist during the Korean War and was a staunch opponent of the Vietnam War), testified before a Senate subcommittee on the psychological impact of combat on soldiers. Lifton stated the same psychological processes (psychic numbing and dehumanization of the enemy) that allowed soldiers to kill on the battlefield also allowed them to commit war related atrocities. Lifton was highly critical of military psychiatrists. He believed these physicians were primarily advocates of the military's interests rather then the welfare of their soldier-patients.

In April, 1971, a young African-American man, Dwight Johnson, was killed while attempting to rob a liquor store. Two-and-a-half years prior to his death Johnson had received the Congressional Medal of Honor for combat heroism. Psychiatrist Chiam Shatan who opposed the Vietnam War, was "deeply moved" by the Dwight Johnson incident. Shatan was concerned about the absence of a war trauma diagnosis in the DSM-II. In a professional paper he wrote of a "post-Vietnam syndrome" (later changed to the broader "post-catastrophic stress disorder") that typically occurred 9 to 30 months after returning from Vietnam, the time frame of Johnson's crime and death. Shatan described a syndrome he called "delayed massive trauma" characterized by guilt, rage, psychic numbing, and alienation.

Robert Lifton and Chiam Shatan became participants in VVAW "rap groups" The two psychiatrists along with VVAW members and others constructed the biographies of more than 700 Vietnam veterans, WW II concentration camp victims, rape victims, and others. Based on these findings Lifton, Shatan, and VVAW member Jack Smith attempted to convince a three member APA committee that some form of trauma induced disorder should be included in the forthcoming DSM-III..

Scott argues that proponents of what became PTSD prevailed "because a core group of psychiatrists and veterans worked consciously and deliberately for years to put it there." They succeeded because they were better organized, were more politically active, and had more lucky breaks during the fight for inclusion than their opponents. The importance of PTSD in the DSM-III cannot be overemphasized as this disorder was now legitimated by the APA. With this new perspective, Scott states, emphasis shifted from the particular details of a troubled solider's background and psyche "to the nature of war itself." In formulating their diagnosis, mental health practitioners would now take seriously "the patient's combat experience." For some veterans PTSD was likely confounded by other issues such as alcohol abuse and related problems.

The creation and inclusion of PTSD in the DSM continues to be a matter of contention. British psychiatrist Simon Wessely asks if PTSD "is a valid psychiatric entity found across time and culture, representing a predict-

able but abnormal response to trauma? Or is it a Western, culture-bound syndrome, created to heal America's guilt over the Vietnam War...?" Psychiatrist Paul McHugh (formerly of Johns Hopkins University) has been one of the harshest critics of PTSD. For McHugh, "a natural alliance grew up between patients and doctors to rectify the existence of the disorder: patients received the privileges of the sick, while doctors received steady employment when, with the end of the conflict in South East Asia, hospital beds were emptying?"

Critics also question the efficacy of the PTSD diagnosis. Has it been successful? How many veterans has it helped and at what cost to taxpayers? According to McHugh, the "inventive construction" of chronic PTSD served as a justification for "service-related psychiatric centers" devoted to treating veterans whether or not they were getting better. McHugh's reading of the evidence is that overall, troubled individuals were not improving.

While the appropriate response to soldiers' psychological, war-induced trauma is open to debate, the reality that combat veterans experience trauma is beyond question and was hardly the "inventive construction" of the VVAW and sympathetic psychiatrists. A 1946 study concluded that after 35 days of sustained combat, 98 percent of World War II soldiers experienced some adverse psychiatric symptoms. Of the 2 percent who did not succumb to battlefield stress, most were characterized as "aggressive psychopathic personalities" who were this way before entering the military.

Richard Gabriel, author of "No More Heroes: Madness and Psychiatry in War" (1987), states that in every 20th century war in which American troops fought the chances of becoming a psychiatric casualty were greater than the chances of being killed by enemy fire. In World War II, just under 406,000 American military personnel were killed while almost 1.4 million suffered psychiatric symptoms severe enough to debilitate them for some period.

Mending broken warriors: treating PTSD

In the American Psychiatric Association's (APS) 2013 Statistic and Diagnostic Manual (DSM-5), Post Traumatic Stress Disorder (PTSD) was changed from an anxiety disorder and moved to a chapter on "Trauma-and-Stress-Related-Disorders." According to the APA, "the trigger to PTSD is exposure to actual or threatened death, serious injury, or sexual violation." This exposure can occur on the battlefield, as a result of a life-threatening natural disaster, a criminal attack, or other traumatic events.

The DSM-5 pays particular attention to four behavioral symptoms that accompany PTSD.

1) *Re-experiencing:* spontaneous memories of the traumatic event, recurring dreams of the event, flashbacks, and other prolonged psychological distress.

2) *Avoidance*: distressing thoughts, feelings and reminders of the event

3) *Negative cognitions and moods*: a variety of feelings about the event including self-blame or blaming others, estrangement from others, and a diminished interest in normal activities.

4) *Arousal*: aggressive, reckless or self-destructive behavior, sleep disturbances, and hyper-vigilance or related problems.

The APA reports some military leaders believe the word "disorder" makes individuals dealing with PTSD symptoms less likely to seek help. These leaders suggest renaming the disorder post-traumatic stress "injury" noting this term is more in line with the language of military personnel and would reduce the stigma of diagnosis.

The growing number of women in the armed forces notwithstanding (14.6 percent as of 2012), the military remains a hyper-masculine organization with even females internalizing the male value of toughness. To have a psychological "disorder" is often interpreted as an individual shortcoming, an internal or inherent weakness of character. To be thought of as such is one of the worst things that can happen to a soldier. The word injury does not carry this disapproving meaning as injuries can and do happen to anyone.

The APA rejected changing "disorder" to "injury" stating the military environment needs to change "so that mental health care is more accessible and soldiers are encouraged to seek it in a timely fashion." A military culture more conducive to the psychological needs of combat veterans is crucial to soldiers getting the help they need. Changing "disorder" to "injury" would be an important step in bringing about this cultural shift

As of June 2010, of the 593,634 Iraq and Afghanistan veterans treated by the VA, 171,423 (28.8 percent) were diagnosed with PTSD. A total of 84,005 veteran-patients were granted VA disability compensation, about half for PTSD. The number of veterans who have PTSD and do not seek treatment is unknown. The relation between PTSD and suicide attempts, and PTSD and completed suicides is also unknown.

Research indicates that certain factors increase the chances military personnel will develop PTSD. These high-risk factors include: longer deployment time, more severe combat exposure including seeing others wounded and/or killed, traumatic brain injury, lower rank, lower level of schooling, not being married, being female, and being Hispanic.

Because the female combat-soldier is a new phenomenon relatively little is known about the unique issues facing these women. Whereas men with PTSD often report flashbacks, nightmares, irritability and anger, women are more likely to experience depressive symptoms. Retired Army psychiatrist Elspeth Ritchie states that female soldiers are "wanting more than anything else to be like the guys, and so they're not necessarily more likely than the guys to report" PTSD symptoms. A female Army captain in Afghanistan who was having trouble with anxiety and sleeping stated: "I remember feeling...as a woman being in command, not wanting to fall into the stereotype of 'We've got another sappy female breaking under pressure.'" She eventually sought help but noted that it wasn't easy.

There are a number of treatment options for PTSD including:

Cognitive behaviorial therapy: a form of talk therapy with the goal of teaching veterans how to think (or rethink) about war trauma and its aftermath. The therapist helps the individual replace deeply troubling

thoughts with less depressing thoughts as well as to inform the veteran how to cope with feelings of anger, guilt, and fear.

Exposure therapy: based on the idea that trauma victims fear thoughts, feelings, and situations that remind them of past traumatic events. By talking about traumatic events repeatedly individuals learn to control or manage these trauma related thoughts and feelings. While talking about war trauma continually may seem counter-intuitive, the goal is for veterans to feel less overwhelmed about their traumatic experiences over time.

Eye movement desensitization and reprocessing therapy (EMDR): a technique wherein a patient's rapid eye movements under the direction of a therapist reduces the power of emotionally charged memories of past traumatic events.

Medication: helpful in some cases. The VA reports that a category of drugs called "selective serotonin reuptake inhibitors" (SSRIs), a type of antidepressant "appear to be useful, and for some people are very effective." Other medications have been used with some success.

Dr. Belleruth Naparstek, who has worked extensively with PTSD patients, states that prayer and/or ritual can help the healing process. Other helpful techniques or activities include regular physical exercise, meditation, self-hypnosis, practicing relaxation techniques including "conscious breathing" and guided imagery. Naparstek, notes that guided imagery can be particularly effective with PTSD patients who struggle to put their feeling into words as they can more easily respond to nonverbal images, symbols, and sensations. According to the VA, cognitive-behavioral therapy and EMDR have been the two most effective PTSD treatment modalities. At least one study found that women respond to treatment as well as if not better than men. This may be so because females are generally more comfortable than males talking about their feelings and painful experiences.

To say that retired Army chaplain Eric Olsen of Saranac Lake knows something about PTSD is an understatement. Colonel Olsen, who served in Iraq, has counseled hundreds of individuals with PTSD as well as severely wounded soldiers at Walter Reed National Military Center and the National Naval Medical Center. Olsen cites Pastor Erwin McManus who believes that for the soul to be content an individual must have purpose, a sense of belonging, and a sense of intimacy. A person can function with two and survive with one, but is in serious trouble if all three are missing. It's not surprising that PTSD symptoms often manifest themselves months after a combat veteran has returned to civilian life and his or her sense of purpose, belonging, and intimacy are being redefined. The former soldier, must, in a sense, create a new self and become part of a civilian world that he or she left years ago. This is no easy task, especially for the veteran who's sense of purpose, content, and intimacy are embedded in the military in general and his or her unit in particular.

Colonel Olsen notes that returning soldiers must ask themselves at least two fundamental questions: "Who are you before God and man? What do you want?" These are hard questions for anyone to answer and can be extremely difficult for combat veterans who have experienced the brutality of war, who were raised with a core "Thou shall not kill" value

and then ordered to kill and watch comrades, and often civilians, suffer and die.

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