CHAPTER 6

POST-TRAUMATIC STRESS DISORDER

6-1. Introduction

a. Over the years, there were sporadic reports of veterans from WWI, WWII, and the Korean conflict who suffered from persistent war neurosis or exhibited disturbed conduct. It was not until the late 1970s that PTSD was recognized as a classifiable psychiatric syndrome. A major driving force was the large number of Vietnam veterans who were suffering from what was at first labeled post-Vietnam syndrome (a pattern of symptoms). This syndrome involved varying combinations of anxiety and hyperarousal, depression and guilt, impulsive or violent behavior, social alienation or isolation, and often substance abuse. The common theme was the intrusive, painful memories of Vietnam and the ways the sufferer used to try to avoid or escape them. The post-Vietnam syndrome was also identified in noncombat military personnel. Similar symptoms and behavior were recognized in combat medics, hospital personnel and female nurses from Vietnam (and prior wars), and in ex-prisoners of war and concentration camp survivors.

b. Also in the mid-1970s, a similar syndrome was being recognized in some traumatic civilian situations, such as victims of natural or human-caused disasters, rape and other violent crimes, and terrorist acts or hostage-taking episodes. The same symptoms were found in many cases of burnout in civilian police, fire, and emergency medical personnel.

c. The American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, 1979, established the criteria for making a diagnosis of PTSD. These were updated in *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (DSM III-R), Washington, DC: American Psychiatric Association, 1987. See Table 6-1 for specifics.

d. The DSM III-R classification recognizes that PTSD can be—

- Acute (beginning within 6 months of the traumatic event, but not lasting longer than 6 months).

- Chronic (beginning within 6 months and lasting longer).

- Delayed (beginning or recurring after 6 months and perhaps even many years later).

Delayed PTSD can usually be related to other stressors going on in the person's life at the time, especially those which remind him of the combat stressors, such as a threat of loss of life, self-esteem, or love relationships.

e. It should be obvious when comparing the criteria in Table 6-1 with the descriptions of battle fatigue in Chapter 5 that if a war or operations other than war continues for more than a month, some of the battle fatigue cases could meet the criteria for a diagnosis of PTSD. However, by US Army convention, the label PTSD will not be used while the soldier is in the theater of operations as battle fatigue more clearly implies the positive expectation of recovery and return to duty without persistent problems, The diagnosis of PTSD will be reserved for symptoms which persist or arise after the cessation of hostilities or after returning to the US.

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6-2. Psychologically Traumatic Events

a. Explanation of Psychological Trauma. Psychological trauma, by definition, involves a crisis situation which makes the person feel he is changed for the worse. The implication is that the victim has suffered psychological injury and bears the psychological scars. To qualify under DSM III-R, the traumatic event must be something which is outside the range of usual human experience; it is an event which anyone would find horribly distressing. It is true that for professions like police, fire fighters, emergency medicine personnel, and the combat soldier many events come to be accepted as routine and even positive that other people would find unusual and traumatic. There remain, always, those terrible events (because of chance or mistake) that one hopes (and deep down believes) will never happen to oneself or one's close friends.

b. Causes Contributing to Post-Traumatic Stress Disorder. Traumatic events tend to be discrete events which provoke especially vivid memories of terror, horror, helplessness, failure, disgust, or "wrongness." Even in prolonged stress situations like being a PW or hostage or serving a medical or mortuary tour in Vietnam, subsequent PTSD will call out specific bad events. The events often (but not always) involve especially vivid sensory stimuli which are distinctly recorded in memory—visual images, smells, sounds, or feelings. The sense of "wrongness" may be from a personal violation or error, or from a sudden realization of the arbitrary unfairness in life as it affects others. So, for fire fighters, the death of children in fires is especially distressing. Combat soldiers who have killed enemies at long range in open battle with pride may be haunted years later by the memory of a soldier they killed in ambush. They are haunted because they searched the body for documents and instead found letters and photographs of loved ones similar to their own. Mortuary affairs personnel, too, tend to suffer when they inadvertently learn too much about the lives of the people whose bodies they must handle.

c. Situations Likely to Provoke Post-Traumatic Stress Disorder. The following is a listing of some of the situations in combat (and civilian equivalents):

- Loss of friends, buddies, and loved ones—
- Under especially horrible circumstances.
- With associated guilt because of an actual or perceived mistake or an error (omission or commission).

- By having exchanged places so that a friend went and died instead of oneself.

- Injury or death to innocents (especially women and children).

- Seeing grossly mutilated bodies or wounds.

- Atrocities (done, condoned, or just observed).

- Lack of respect; lack of ceremony and "closure" for deceased friends.

- Lack of apparent meaning or purpose to the sacrifice, as might result from careless accidents or military errors.

- Inadequate quality of the homecoming reception which fails to validate the sacrifices and inhibits talking out the bad memories with family, friends, or fellow veterans.

d. Symptoms of Post-Traumatic Stress Disorder.

(1) As the DSM III-R criteria (Table 6-1) reveal, PTSD is driven by intrusive memories of the traumatic event. These may come while awake or in dreams. The memories may come when a person is intoxicated. Occasionally these memories can be so vivid and multisensory that the person feels briefly he is reliving the experience (called a flashback). These thoughts are often triggered by sensory stimuli like those of the original events, such as objects, helicopter sounds, or smells. They become more intrusive for a while after the initial reminder. Because the memories are painful, the person with PTSD tries to avoid things that bring them on and may be quite successful.

(2) The memories themselves do not constitute PTSD. The issue is whether (and how) they interfere with general well-being, happiness, and occupational or social functioning. For example, an infantry battalion colonel who had been a company commander in Vietnam described how he could still not see a piece of trash on the ground without suddenly becoming alert and being inclined to stay well away from it. Along with this would be painful, vivid memories of the horrible wounds which his young soldiers had suffered from booby-trapped trash. The colonel, however, does not see himself as scarred by those memories. Rather, he reassures himself that it was a hard lesson he has not forgotten and that if his unit should find itself in a similar war, he will see that his men do not have to learn this lesson in such a hard way again. He has reframed the painful memories in his mind so that they resulted in positive growth rather than an unhealed scar.

(3) The colonel (mentioned above) did say that for several years after returning from Vietnam, he had experienced other symptoms which approached those of PTSD. He felt isolated and alienated from other people, especially from civilians and other Army coworkers who had not been in Vietnam. He felt they could not understand what it was like and did not want to hear about it. He felt considerable anger towards them and held his temper chiefly by keeping to himself. He also tended to shut out his wife and children that way for a while.

(4) In more extreme cases, the isolation takes the form of an inability to feel affection or form close relationships. In losing close friends in combat, the soldier learned not to get too close again to the new replacements. The pattern has continued involuntarily. Negative feelings towards women and children (such as mistrust combined, perhaps, with guilt) may also have been acquired by the types of interactions encountered in the combat zone. The veterans

with PTSD may go emotionally numb, continuing to function without any feeling when something happy or sad occurs.

(5) The angry and hostile feelings may stay tightly suppressed, as in the infantry colonel's expedience described above, or they may erupt in angry outbursts or even in rage and violence. The ex-combat soldier who was once authorized to use lethal force in combat missions (and perhaps went beyond that to exercising force in the form of misconduct stress behaviors) has the memory of that power to provide temptation or self-justification for using violence again. This is especially likely when inhibition is impaired by alcohol or other intoxicant drugs. See Chapter 4 for details on misconduct stress behaviors.

(6) Substance abuse, especially alcohol, is common with PTSD. It provides an escape from or dulling of the memories. It is often used to try to get to sleep without the bad dreams and to reduce the anxiety and tension.

(7) Post-traumatic stress disorder characteristically involves symptoms of anxiety and hyperarousal—exaggerated startle responses or excessive alertness and vigilance for potential threats. These may be the threats of the past combat situation (such as the colonel's alertness about the trash or automatically noting potential ambush sites), or it may lead to excessive suspicion and caution in daily life (such as sleeping with a loaded pistol under the pillow or never sitting with one's back to a crowded room).

(8) Depressive symptoms, with poor sleep, loss of appetite and other pleasures, poor concentration, and guilt feelings are also characteristic of true PTSD. The sufferer is preoccupied with what he did or did not do to survive when others died. He may blame himself for mistakes that were real or quite beyond his control. He may have guilty thoughts, such as "If only I had not been so slow" or "If only I had been six feet closer, I would have seen that sniper before he shot my friend." The risk of suicide in PTSD is related to this depression and should not go unrecognized. It may also lead to reckless, potentially self-destructive behavior without conscious suicidal intent.

e. Early (Preventive) Treatment of Psychological Trauma.

(1) An analogy has been made between psychic trauma and physical trauma, such as lacerated muscles and broken bones, People sometimes try to reassure the traumatized victim with the saying, "Time heals all wounds," This reflects the common observation that feelings of grief, loss, and guilt do normally tend to fade with time. But the analogy with physical wounds suggests the fallacy in such reassurance.

(2) Time heals broken bones, but only if they have been carefully realigned and stabilized to permit correct healing to begin. Time heals lacerated muscles, but only if they do not become badly infected by bacteria and dead tissue trapped in the wound. One of the most important lessons of combat wound surgery is not to attempt immediate primary closure (stitching the muscle and skin together again) as would be done in civilian hospital surgery. Instead, it is better to leave the wound open, keep it clean, and let it heal from the inside out for a few days. It can then be closed under sterile hospital conditions to decrease the size of the scar.

(3) With especially traumatic physical injuries, such as high-velocity bullet wounds, the surgical treatment is even more stringent. The surgeon provides immediate intervention to stop the bleeding. He then debrides dead tissue and surgically repairs the wound. In many cases the surgeon may delay primary closure and insert a drain which allows the wound to heal from the inside out.

(4) This analogy between physical traumatic injury and psychic traumatic stress appears accurate regarding immediate treatment. It is best not to attempt immediate primary closure of psychic trauma by forcing the feelings out of mind and pressing on with other tasks that keep the disturbing feelings from surfacing. Instead, it is better to open up the psychic wound and let it drain. It may even be necessary to "insert a drainage tube" (to permit proper healing)—that is until the sufferer actually feels and expresses the suppressed, painful emotions and allows them to come out. This should be done as soon as the soldier who is suffering can pull back from the mission safely and regain (through brief rest and physical replenishment) the strength and clarity of mind needed to participate in his therapy.

(5) Another analogy perhaps more familiar to the nonmedical leader is the preventive maintenance of complex equipment. A good officer or NCO would not accept bringing an M1A1 tank (or an M16 rifle) back from fighting in a sandy desert or muddy/salt marsh without performing maintenance. This maintenance includes cleaning, re-oiling, and preparing the M1A1 tank for its next mission. The good leader knows that even though the dirt has not already jammed the weapon, the salt particles or sand grains will greatly increase corrosion and wear, The result could be unreliable performance, increased maintenance costs, later catastrophic failure, or maybe just a decreased useful life. Especially traumatic memories can have the same corrosive effect on the individual. They can impair the soldier's future performance. They can result in much unnecessary pain and suffering, both to the soldier and his family.

f. Small Group After-Action Debriefing.

(1) Every small unit leader should routinely conduct after-action debriefings following any difficult situation. This is especially important if mistakes or misunderstandings occurred or losses were suffered. After-action debriefing for stress control may be integrated into the routine after-action review if the time available does not permit the separation of the two.

(2) The after-action review should be practiced in training and continued in conflict or war. The after-action review should be conducted as soon as it is safe for the leader to bring his team together. The purpose of the after-action review is to talk about the details of the recent action and agree on lessons learned. The first step is to agree on what actually happened. It may be necessary to share everyone's observations to get a clear picture. The after-action review focuses on how well the battle/crew drill or TSOP worked. What went well and needs no change? What could use further improvement? What did not work at all and needs a new approach? When properly conducted, the after-action review increases understanding, trust, and cohesion within the team. It builds confidence that future events be handled even better.

(3) The after-action debriefing process shares the after-action review's concerns with details of what happened. It goes further by actively encouraging the team members to share and talk out their emotional responses to the event. After-action debriefings should also be routine during training, operations other than war, and war following any difficult or unpleasant event. Doing after-action debriefing routinely will make them second nature following any especially traumatic event. The objective of after-action debriefings following traumatic incidents is to promote "healing" by opening up, "cleaning and draining" any unpleasant or painful memories. Table 6-2 lists the key steps of the after-action debriefing process and Appendix A provides additional information.

(4) Leaders and buddies have the responsibility of continuing to talk through

especially traumatic events. This should be done in a supportive way to individuals who show signs of distress in the after-action debriefings through personal conversations. Unit ministry teams may be helpful in the debriefings and in individual pastoral counseling to help the soldier redirect the painful memories toward positive spiritual growth. Individual referral to mental health/combat stress control personnel is indicated for severe distress.

Table 6-2. Key Steps in an After-Action Debriefing

- EXPLAIN THE PURPOSE AND GROUND RULES TO BE USED DURING THE DEBRIEFING AT THE OUTSET.
- INVOLVE EVERYONE IN VERBALLY RECONSTRUCTING THE EVENT IN PRECISE DETAIL.
- ACHIEVE A GROUP CONSENSUS, RESOLVING INDIVIDUAL MISPERCEPTIONS AND MISUNDERSTANDINGS AND RESTORING PERSPECTIVE ABOUT TRUE RESPONSIBILITY.
- ENCOURAGE EXPRESSION (VENTILATION) OF THOUGHTS AND FEELINGS ABOUT THE EVENT.
- VALIDATE FEELINGS ABOUT THE EVENT AS NORMAL AND WORK TOWARDS HOW THEY CAN BE ACCEPTED, LIVED WITH, ATONED.
- PREVENT SCAPEGOATING AND VERBAL ABUSE.
- TALK ABOUT THE NORMAL (BUT UNPLEASANT) STRESS SYMPTOMS UNIT MEMBERS EXPERIENCE AND WHICH MAY RECUR FOR A WHILE, SO THEY, TOO, CAN BE ACCEPTED WITHOUT SURPRISE OR FEAR OF PERMANENCE.
- SUMMARIZE THE LESSONS LEARNED AND ANY POSITIVE ASPECTS OF THE EXPERIENCE.

g. Following Up the After-Action Debriefing.

(1) People who live through extremely traumatic experiences should not expect to forget them. It is entirely normal to remember such events with sadness, resentment, guilt, or whatever emotions the event deserved. It may be appropriate to atone for mistakes made. It is also normal to dream about the event, even many years later. The "normal" pattern is for these painful feelings to become less intense and less frequent as they are balanced by later, positive events.

(2) Combat stress control/mental health personnel should always be notified whenever serious psychological trauma has occurred in a unit. They can assist command in assuring that the after-action debriefing process is done correctly. When indicated, the unit should arrange for combat stress control/mental health personnel to conduct a critical event debriefing. Critical event debriefings are similar to after-action debriefings but differ in the following ways:

- The critical event debriefing is led by a trained debriefer who is not a member of the unit being debriefed; the after-action debriefing is led by the small unit's own leader.
- The critical event debriefer explicitly defers issues of operational lessons learned in order to focus on the stress aspects

and stress responses; the after-action debriefer does seek to capture relevant operational lessons learned in positive terms.

(3) Prior to redeployment home, units should schedule time for everyone to verbally review the high and low points, talk through any unresolved issues, and conduct memorial ceremonies, if appropriate. Chaplains and combat stress control/mental health personnel should also take an important supportive role in these activities.

h. Cautions for Preventiue Intervention After Traumatic Stress.

(1) The analogy between PTSD preventive interventions and traumatic wound surgery suggests a cautionary warning. If the surgery is not done skillfully, it can cause more harm than good, leaving dead tissue and bacteria in the wound. It may cut away tissue that did not need to be sacrificed, or realign the broken bones incorrectly. The same is potentially true for poorly executed after-action debriefings or critical event debriefings.

CAUTION

A poorly executed stress debriefing can cause harm. It can—

- Leave important and painful issues unexplored, waiting to fester into future PTSD which will be harder to treat.
- Compound rather than relieve the feelings of guilt, anger, and alienation.
- Glamorize and encourage chronic PTSD disability.

(2) The problem for early prevention efforts is to forewarn of possible post-traumatic stress symptoms without glamorizing them or advertising them as a reimbursable long-term disability. To do the latter invites malingering. It also subtly encourages those who do have real but not disabling post-traumatic symptoms to magnify them. This will be especially likely if they have other psychological issues or grievances which the symptoms also address, such as feeling unappreciated for the sacrifices suffered or guilt at having left their buddies.

(3) As with the treatment of acute battle fatigue, it is essential that all persons involved in preventive or treatment interventions for PTSD express positive expectation of normal recovery. At the same time, they must indicate that continuing or recurring symptoms can and should be treated, still with positive expectation of rapid improvement. They should advise that post-traumatic stress symptoms may recur in the future at times of new stress. Successful treatment after future episodes should deal with the ongoing, new stressors as much as with the past trauma.

6-3. Identification and Treatment of Post-Traumatic Stress Disorder After the War

a. Because PTSD can recur months or years later (usually at times of added stress), coworkers and supervisors, chaplains, and health care providers should all be alert to the often subtle signs of PTSD long after combat. They should provide normalizing support and encourage (or refer the soldier for) mental health treatment.

b. Remember, one of the common symptoms of PTSD is social alienation,

withdrawal, and attempts to avoid reminders of the memories. Sufferers of post-traumatic stress symptoms are, therefore, not likely to volunteer their combat history or to admit easily to the "weakness" of not being able to control their painful memories. In fact, many soldiers with PTSD from prior combat (or accident or disaster) present as eases of substance abuse, family violence, or other misconduct. They will not receive the mental health help they deserve unless the causal stress relationship is explicitly asked about and recognized.

c. Another hidden cost of inadequately treated post-traumatic stress will be the potentially large number of combat-experienced veterans (especially in the elite units) who either ask for transfer out of the combat unit, do not reenlist, or submit resignations. They will often say "My spouse wants me to leave the Army, and was especially worried that I almost got killed in that last deployment." Only with careful exploration will it become clear that the spouse is not upset with the Army or its risks but because the soldier came home changed. He keeps to himself, will not say what is wrong, gets mad at the children, drinks too much, and wakes up at night shouting and crying. The spouse thinks that if the soldier can only get away from the Army, he will get back to the way he was before. Unfortunately, if simply allowed to resign, whatever guilt, shame, or other traumatic memory is haunting him will probably continue unresolved.

6-4. Combat Stress Control (Mental Health) Personnel Responsibilities

a. Combat stress control personnel have critical roles in assisting command in the prevention and early recognition of PTSD and in treatment of the individuals to avoid long-term suffering or disability following traumatic combat experiences. Treatment is often best when conducted in groups. The Department of Veterans Affairs (veterans' counseling centers) also may provide valuable consultation and treatment expertise. Whenever the Department of Veterans Affairs is involved, however, special care should be taken to avoid the negative expectation of long-term treatment and chronic disability reimbursement.

b. Post-traumatic stress disorder also occurs following natural and accidental disasters, terrorist attacks, rape or criminal assault, and hostage situations. Mental health/combat stress control teams have consistently demonstrated their value in rapid deployment of medical response teams for such contingencies. Their involvement following such incidents, as well as following combat, should be requested by the chain of command according to standing operating procedure.