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## Combat-related trauma : an historical analysis through a biopsychosocial lens

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## CHAPTER I

### INTRODUCTION

The purpose of this study is to examine the *biopsychosocial* effects of combat-related trauma in veterans with the purpose of guiding treatment. This research will examine the literature pertaining to combat-related trauma from the First World War (WWI) to current conditions experienced in Afghanistan and Iraq, so as to compare and contrast the biopsychosocial effects of trauma from a historical war-time lens. This lens will feature a clinical social work perspective on how the understanding and treatment of trauma has evolved throughout the years beginning with the first students of The Training School of Psychiatric Social Work at Smith College in 1918.

While it has been suggested that important groundwork for military psychiatry was established before WWI, this researcher argues that it was the scale and magnitude of soldiers afflicted with combat-related trauma during the First World War which served as the means by which attention was finally drawn to this otherwise little studied phenomenon. Industrial production of artillery and the use of machine guns created casualties of massive scale, with over 8 million soldiers killed world-wide and more than 21 million treated for physical injuries (“World War I,” 2007). Many of those who survived the assault were affected psychologically by the trauma they had witnessed, and they sought refuge in the care of psychiatric interventions.

Despite the fact that the early psychiatric community initially contributed some aspects of trauma to physical cause, in particular *shell shock*, it soon became clear that soldiers who had *not* been exposed to physical trauma were still capable of developing the symptomatology (Salmon, 1917), and many who *had* encountered heavy shellfire were symptom-free (Shephard, 1999). Once it became apparent that etiology was psychological in nature, a debate quickly formed between traditionalist and progressive perspectives. Traditionalists contended that soldiers who developed war related *neurosis* were of questionable moral fiber and viewed such individuals as “constitutionally inferior” (Herman, 1992, p. 21). This viewpoint was consistent with Darwinian thinking at the turn of the 19<sup>th</sup> century, whereby individuals suffering from such disorders must be biological mutations with little hope for recovery. In opposition to this stance, progressives claimed that combat neurosis was a psychological condition that could occur in any given man, including soldiers of high moral character; that recovery was possible and individuals could be reintegrated into society with positive results (Herman). Treatment strategies and interventions were based upon one’s particular theoretical perspective, but they all had the same goal - to return the soldier to combat duty.

Although this debate occurred nearly a century ago, the question of morality in the form of stigma still persists with regards to current mental health interventions with returning Iraq veterans diagnosed with *posttraumatic stress disorder* (PTSD). Recent data in the area put the pool of American combat veterans in Iraq at 433,398 (Figley, 2006). At this moment in time, the U.S. has approximately 150,000 troops based in the region consisting of Active Duty personnel (43%), and those serving in the Reserve and National Guard (57%) (Figley). The number of returning combat veterans from Iraq

seeking mental health services is estimated to be between 25 and 35 percent (Figley; Hoge, Auchterlonie & Limmiken, 2006), with a further 60 percent unlikely to seek help due to fears of stigmatization or loss of career advancement opportunities (Figley, 2006).

The questioning of moral character is a thematic example linking findings from WWI to the present conflict in Iraq. Throughout history it has been suggested that military planners forget the hard-fought wisdom of previous wars only to have to rediscover it in battle (Jones & Wessely, 2005; Strecker, 1944). While some literature discussing the psychological, physical, and social effects of combat trauma is available for perusal, studies to date focus primarily on Vietnam veterans; with little or no information pertaining to veterans from WWI, WWII, the Korean War, the Persian Gulf War or those serving in the ongoing conflict in Iraq. This author argues that much can be gleaned from further research into the treatment modalities and biopsychosocial effects of trauma from these battles. Although the type of warfare currently being conducted in Iraq is very different from past wars and highlights the need for studies of members of the armed services who are involved in the current operations, we must also consider the methods, explanations, and outcomes developed from previous wars in order to reflect upon “lessons learned” (Hoge, et al, 2004; Jones & Wessely).

By the end of fiscal year 2004, the number of veterans in the United States numbered well over 26 million with 16 million veterans under the age of 65 (U.S. Department of Veterans Affairs, 2006). Regarding demographics, an estimated 7 percent of women veterans are of Hispanic origin; 70 percent White non-Hispanic; 18 percent Black non-Hispanic; 1 percent American Indian non-Hispanic; 2 percent Asian non-Hispanic; less than 1 percent Pacific Islander non-Hispanic; and 2 percent denoted as

other or multiple race non-Hispanic (U.S. Department of Veterans Affairs, 2006). The estimated distribution among male veterans is somewhat different from that of female veterans, with a lower proportion of Hispanics (of any race) and minority races.

Hispanics make up 5 percent of male veterans; White non-Hispanic, 82 percent; Black non-Hispanic, 10 percent; American Indian non-Hispanic, 1 percent; Asian non-Hispanic, 1 percent; Pacific Islander non-Hispanic, less than 1 percent; and other or multiple race, 1 percent (U.S. Department of Veterans Affairs).

This demographic data suggests a fair amount of diversity within our armed forces, and is similarly reflected in the personnel currently serving in Iraq. What is not reflective of this diversity is the research surrounding the phenomenon of combat-related trauma. In very few cases, where the effects of trauma are disseminated and reported in an empirical manner, is there a break-down of possible differences reflective of race or socio-cultural background. For example, through empirical research studies we know relatively little about the diversity of soldiers who served during WWI, but fragments of literature suggest that many minorities served in the military during this period. A newspaper article from a 1919 issue of *The Union*, located in the archives of the Ohio Historical Society, details how 124 African American soldiers were honored by France for extraordinary heroism through the 371<sup>st</sup> and 372<sup>nd</sup> Infantry Divisions. The soldiers originated from South Carolina, Massachusetts, Washington, D. C., Maryland, Ohio and Tennessee, and they received the *Médaille Militaire* and the War Cross; both highly coveted commendations. It is likely that a proportion of these soldiers may have suffered from combat-related trauma issues, but nowhere is there mention of this in the literature.

The relevance of this thesis to the profession of social work is highly significant. The Training School of Psychiatric Social Work at Smith College was established in 1918, with the first group of graduates entering the field in 1919. According to W. A. Neilson, LL.D., President of Smith College, the entire premise behind the graduate school's establishment was to be of service to the country during war time by educating individuals who could assist in the psychiatric treatment of returning soldiers (1918). Understanding the social and political milieu from which students practiced, along with patients' symptomatology and ensuing interventions of the era, will be an invaluable source of information for current schools and students of clinical social work practice. Only through the transparency of history can we acquire a true understanding of how the phenomenon of trauma has evolved and matured to present day. To this end, relative supplementary questions will be addressed such as: What were the trauma symptoms of the time and how were they treated? How has treatment of combat-related trauma impacted theoretical focus, and vice versa? Are there similarities today with past techniques and interventions? What, if any, interventions seem to work? What have we learned?

Nowhere in the literature is there a historical record comparing and contrasting the intricacies of combat-related trauma from WWI to current Iraq veterans from a clinical social work outlook. Our lens is unique. As modern-day clinical social workers we are trained to incorporate a biopsychosocial perspective with regards to treatment approach. The biopsychosocial model was first introduced by psychiatrist George Engel in the 1970's as a way of looking at the mind and body of a patient as two important systems that are interlinked (Dowling, 2005). The model treats the biological,

psychological, and social structures as united systems of the body, in contrast to the traditional biomedical model of medicine which disregards the psychological and social elements (Dowling).

Incorporating a biopsychosocial focus with respect to combat-related trauma provides an opportunity to entertain an all-inclusive view of assessment and treatment; valuing each component equally and understanding that “all human life is shaped by the interplay of forces that arise from within and without” (Berzoff, Melano, Flanagan & Hertz, 1996). Not only will this focus allow us a more complete understanding of how trauma has shaped both the inner world and interpersonal relationships of our veterans, it furthers our clinical capabilities in responding to the complexity of circumstances to which these soldiers have been exposed.

To date there are several civilian treatment modalities used with regards to trauma, but still relatively little data available to guide the treatment of veterans with combat-related trauma (Turner, Beidel & Frueh, 2005). In gathering additional data on this phenomenon by using a chronological approach, the desired outcome of this research is to enhance the care provided to our combat veterans. To this end, the grand tour question of this study remains: How has combat-related trauma historically impacted the lives of returning veterans from a biopsychosocial perspective?

## CHAPTER II

### METHODOLOGY/CONCEPTUALIZATION

It is the normal conceit of human nature to believe “our time” is somehow unique or special when in fact history has an uncanny capability of repeating itself while politicians, generals, business leaders, and much of the human race chooses to ignore historical events without taking advantage of lessons learned. Clinicians can fall into this same trap, especially those who dedicate themselves to treating combat-related trauma which transpires during intermittent periods of warfare. It is the intent of this author to review the historical impact of combat-related trauma from the First World War to current operations in Iraq and Afghanistan to remind interested readers of the historical components which have transpired in this field, with the purpose of guiding future treatment interventions. The question this researcher has been most interested in answering is: How has combat related trauma historically impacted the lives of returning veterans from a biopsychosocial perspective? Supplementary questions include:

1. What was the prevalence of trauma within each of these periods?
2. How did the treatment of trauma during various historical battles improve mental health and functioning of soldiers?
3. How does the socioeconomic and political zeitgeist affect methods, explanations and outcomes surrounding this phenomenon?



4. How have the curriculum, instruction and theoretical approaches evolved at the Smith College School for Social Work from their first conception during WWI to reflect the current biopsychosocial needs of our soldiers?
5. What have we learned?
6. What are the treatment implications?

This project discusses several themes which consistently reappear in the literature spanning nearly 100 years. These include:

1. Past and present military efforts to quickly treat affected soldiers so as to return them to the front lines as soon as possible.
2. Familial and societal expectations that returning soldiers will fall back into their respective roles after a brief respite.
3. Traditionalist/Military attitudes about trauma – the Darwinian perspective that individuals suffering from this disorder are constitutionally inferior.
4. Individual reactions of the soldiers themselves to these familial, societal, and militaristic expectations – anyone who fails to meet these expectations is dismissed even though they, themselves, are victims of war.
5. Psychiatric perspectives, then and now, which tend to focus on the diagnostic, or medical, view of trauma through a pathological lens, as compared to the current clinical social work perspective which views trauma through a biopsychosocial lens.
6. Psychiatric and mental health views that individuals stricken with mental illness often have a biological disposition, or weakness, which is triggered by an environmental event.

7. Social work theoretical perspectives at the turn of the century – their “buy in” to the psychiatric diagnostic model instituted by Freud. (The diagnostic school which became the hegemonic theoretical perspective of clinical social work). How has this perspective evolved over the years?
8. Early VA and psychiatric approach to taking care of traumatized vets: diagnose and medicate. Rehabilitate those who are viewed as worth saving, and institutionalize those whom doctors consider expendable. Is this model still practiced today?

In order to break the project down into manageable proportions this author adheres to the following chapter outlines:

#### Chapter I. Introduction.

The introduction consists of a clear statement of the phenomenon being explored with a clear presentation of needs as expressed by: the literature, the projects connection to the field of social work, a clear reason why the reader should be interested in the phenomenon, a summary of what is to follow, and a transition to the second chapter.

#### Chapter II. Methodology/Conceptualization

#### Chapter III. Shell Shock to PTSD – A Century of Trauma

This chapter details trauma in its many forms including soldier’s heart, shell shock, railway spine, combat fatigue syndrome, etc., and their evolution to present day posttraumatic stress disorder. Questions asked and answered include: What is combat-related trauma? What are the symptoms and how have they evolved over the past century? How was combat-related trauma treated in the past, and how is it presently

treated? Does combat-related trauma differ from other forms of trauma? Does combat-related trauma need to be approached any differently from other forms of trauma with regards to treatment? What treatment methodologies work for combat-related trauma? Are there interventions practiced that do not work? What are the resilience and risk factors associated with combat-related trauma? Are there ethnic/socioeconomic/cultural differences among soldiers that might determine who will contract combat-related trauma and who will not? And finally, what are the individual, familial, and societal costs of combat-related trauma?

#### Chapter IV. WWI – WWII – Korean War

This chapter asks and answers several questions regarding trauma during WWI, WWII and the Korean War including: What was the prevalence of combat-related trauma from each of these conflicts? Who was involved in the treatment of combat-related trauma? How did the social/political/economic/military milieu encountered during these timeframes effect treatment, methods, explanations, and outcomes of combat-related trauma? Who were the individuals and/or events that contributed to our understanding of combat-related trauma? What were the known causes of combat-related trauma during these periods? What, if any, were the predictors? What procedures were put into place regarding preventative measures? What was the community impact/expectation/understanding of combat-related trauma? Who served in combat during these wars and what were their perspectives?

#### Chapter V. The Vietnam War

The Vietnam War was unlike any conflict preceding it or any battle which has since transpired. This chapter discusses the elementary differences between the Vietnam

War in comparison to conflicts which occurred both pre and post Vietnam, so as to increase the reader's understanding of combat-related trauma during this timeframe. It then proceeds to answer the same questions proposed in Chapter IV, but specific to the zeitgeist of this era. Discussion of a few contributing individuals and events is presented, as well as issues surrounding veteran reintegration, intertwined with soldier's narratives.

#### Chapter VI. War in the 21<sup>st</sup> Century

This chapter discusses events pertaining to the economic, social, and political milieu relevant to furthering understanding of how combat-related trauma evolved during the late 20<sup>th</sup> century. Questions similar to those posed in Chapter III are addressed; personal vignettes of soldiers who served, issues related to reintegration, and current military protocol are considered in order to appreciate etiology and pathology of PTSD, as we have come to understand the illness, in the 21<sup>st</sup> century.

#### Chapter VII. Smith College School for Social Work and Combat-related Trauma

This chapter examines how the Smith College graduate school's curriculum, methodology, theoretical perspective, and utilization of treatment models have influenced students, from WWI to present day, in their attempts to work with returning veterans diagnosed with combat-related trauma. It also synthesizes prior chapters from a clinical social work perspective so as to discuss treatment implications. Questions asked and answered include: How has curriculum evolved over the century to better reflect the needs of returning soldiers suffering from combat-related trauma? What theoretical models have most influenced the school's perspective, and how have those models served to prepare students from trauma treatment interventions? What have we learned? What do we need to implement, if anything, in order to make us more effective in treatment

dynamic? A case study is presented to reflect current perspectives in the assessment, diagnosis, and treatment of combat-related trauma from a Smith graduate student stance.

#### Chapter VIII. Discussion

Chapter VIII synthesizes the voluminous literature covered in earlier chapters of the thesis and will tie together evolution, practices, and themes of combat-related trauma from WWI through OIF and OEF. This chapter also discusses what we have learned by synthesizing treatment methodologies from historical and empirical perspectives. Barriers to treatment are addressed and future treatment interventions are recommended, in a section titled “moving forward.” Treatment recommendations are followed with suggestions for Smith College School for Social Work curriculum implementation in a more thorough manner than that adhered to in chapter VII. Finally, strengths and weaknesses of this thesis are presented along with final conclusions.

The intent of this thesis is for clinical social workers and others in the field of mental health to garner a valuable biopsychosocial perspective in learning how to better assess, treat and assist in the reintegration of returning veterans suffering from PTSD. Information obtained in this study is used to propose specific treatment interventions for combat-related trauma as well as curriculum adjustments at the Smith College School for Social Work. A lack of current research leaves mental health practitioners with little understanding of the uniqueness of OIF and OEF veterans, or the historical contributions to current thinking. This limits choice when deciding which therapeutic approach to employ and how it should be utilized to best serve the needs of the soldier at hand. The purpose of this study is to historically examine combat-related trauma from a biopsychosocial perspective with the intention of guiding treatment.

## CHAPTER III

### SHELL SHOCK TO PTSD: A CENTURY OF TRAUMA

*"Battling the Effects of War: Combat can Wound the Mind. New Science Helps Vets from Iraq to Cope"*

*Tyre, Newsweek, 2004*

*"Mental Disorders Plague Iraq, Afghanistan Vets: Stress Disorders up dramatically in last 18 months, Affecting 1/3 Vets"*

*The Associated Press, 2006*

*"Battlefield Flashbacks: For Many Vietnam Veterans, the Iraq War is a Trauma Trigger"*

*Ephron, Newsweek, 2006*

Americans can no longer turn on their television sets, open a newspaper, or flip through a magazine without encountering a barrage of headlines pertaining to the current wars being fought in Iraq and Afghanistan. At a steadily increasing rate these headlines are focusing on the mental wounds of our combat soldiers, and Americans are slowly beginning to realize that the costs of war are not simply economic in nature, but much more complex with far reaching consequences. Combat-related trauma comes in many forms, differs in some ways from civilian trauma, and has several risk and protective factors that can accelerate or ameliorate sequelae. Not only do survivors fight a daily battle for sanity and perspective, but their trauma takes a large toll on individual physical and spiritual well-being. Families and communities surrounding such individuals are significantly impacted by their disability, as are the organizations, hospitals, etc. that treat

their physical and mental health needs spending endless time and resources exploring treatment efficacy and outcome.

This chapter will attempt to chronologically synthesize the evolution of the combat-related trauma diagnosis and answer the following questions: What is combat-related trauma? What are the symptoms and how have they evolved over the past century? How was combat-related trauma treated in the past, and how is it presently treated? Does combat-related trauma differ from other forms of trauma? Does combat-related trauma need to be approached any differently from other forms of trauma with regards to treatment? What are the resilience and risk factors associated with combat-related trauma? What are the individual, familial, and societal costs of combat-related trauma?

### *The Many Forms of Combat-Related Trauma and its Symptomatology*

Combat exposure is not a recent development by any means – American soldiers have been treated for combat-related trauma since the birth of our nation. Significant research to date shows that one of the primary causal stressors of combat-related trauma is *direct* combat (Hoge et al., 2004; Kang, Natelson, Mahan, Lee, & Murphy, 2003). During direct combat soldiers are likely to participate in the killing or injury of another; they are liable to see someone they know killed or injured; and they are prone to prolonged exposure to trauma over a significant time span. But direct combat is not the only source of combat-related trauma. While direct combat is an obvious stressor during times of battle, a war environment can create numerous opportunities for exposure to traumatic events among servicemen and women whatever their responsibility or mission.

In a recent report by the Institute of Medicine (2006), researchers detail the types of traumatic stressors encountered during wartime to also include serving in medical units, searching for enemy combatants, work involving the registration of graves, sexual assault or severe sexual harassment, driving vehicles at risk for encountering road side explosives, and patrolling the streets.

Military psychiatry is generally believed to have begun in World War I (WWI) along with the recognition of psychiatric injury (Jones & Wessely, 2005). Prior to this Great War, medical practitioners had observed other acute effects of battle, which were understood to be primarily organic or biological in nature. *Irritable heart, disordered actions of the heart, cerebro-spinal shock, wind contusions, nostalgia, Crimean fever, railway spine, traumatic neurasthenia, kriegsneurosen, nevrose de la guerre, and cerebro-medullary shock* were all diagnoses developed before WWI (Deutsch, 1944; Jones & Wessely; Salmon, 1917; Schwab, 1920). A variety of somatic and behavioral symptoms presented in these disorders and included extreme physical exhaustion, palpitations, headaches, pains in the back and limbs, weakness of the muscular system, partial paralysis, melancholy, insomnia, facial ticks, visual impairment, nervous debility, battle nightmares, psychoses, and delusions (Jones & Wessely; Pizarro, Cohen-Silver, & Prause, 2006; Salmon). Instead of surmising the possibility that etiology of these ailments might be psychological in nature, most physicians prior to WWI preferred to view the phenomenon as signs of abnormal processes in the central nervous system or a consequence of a “depression of the vital forces” (Deutsch, p. 382; Jones & Wessely). In other words - entirely physiological.



With the onslaught of WWI, one diagnosis in particular quickly dominated military psychiatry and became pivotal to the dialectic etiological argument of biological vs. psychological. *Shell shock* was first used to describe nervous symptoms that soldiers exhibited who had been directly exposed to shell fire and explosions. Initially, it was understood that forces of compression and decompression, resulting from proximity to an explosion, in turn led to microscopic brain hemorrhage (Herman, 1992; Salmon, 1917; Shephard, 1999). Frederick Mott, founder of the Maudsley laboratory in England (1916), also hypothesized that cerebral poisoning could be an additional cause due to carbon monoxide released by the explosive blast (Jones & Wessely, 2005). With soldiers experiencing such a large scope of unexplained symptoms including fatigue, insomnia, nightmares, jumpiness, palpitations, chest pain, tremor, joint and muscle pains, and functional paralysis, doctors were having a very difficult time understanding and treating this phenomenon. Complicating matters was the similarity of symptoms with soldiers suffering from various types of gas poisoning. One test used to determine whether the possibility of chemical warfare was an issue, and to ascertain diagnosis, was to provide soldiers with a large meal. Those who were able to eat and digest it were often sent back to the front lines as testimony to their good health (Jones & Wessely).

Much of the same symptomatology experienced by soldiers during WWI was also experienced by soldiers during WWII; albeit by a different name. *Combat fatigue syndrome* was characterized by symptoms of depression, irritability, fatigue, restlessness, jumpiness, difficulty staying asleep, poor concentration, and excessive sweating and headaches, impaired efficiency, morale and social adjustment (Jones & Wessely, 2005). It was initially addressed diagnostically as *battle exhaustion* to take the impetus off

mental illness while suggesting that a regiment consisting of proper diet and rest would restore affected soldiers to optimum health. During the Korean War this same ailment was referred to as *combat exhaustion*, and was a major medical concern for U. S. military forces. During this conflict, which took place between 1950-1953, psychiatric casualties have been listed as high as 37 per 1,000, considerably higher than those endured in Vietnam (12 per 1,000) (Jones & Wessely). But while U.S. soldiers in Korea experienced onset of trauma symptomatology during two phases of the war, which were characterized by mid to high intensity fighting (Jones & Wessely, 2005), Vietnam veterans experienced trauma very differently.

Initially the Vietnam War was credited with limiting psychiatric morbidity but, as the veterans started to reintegrate into society, mental health professionals began to notice a delayed onset of combat-related trauma symptoms. First described as *post-Vietnam syndrome* and later as *catastrophic stress disorder* with the sub-category *post-combat stress reaction* (Shatan, 1978; Haley, 1978), *posttraumatic stress disorder* (PTSD) was introduced into the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-III) in 1980. As defined in the fourth edition (DSM-IV-TR, 2000), “the essential feature is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person” (American Psychiatric Association, 2000, p. 463).

PTSD symptoms fall into three main categories: intrusion, avoidance, and increased arousal. With intrusion the traumatic event is persistently re-experienced in

distressing dreams, flashbacks, illusions and hallucinations, and upon exposure to experiences that symbolize or resemble the traumatic event. Avoidance of stimuli (thoughts, feelings, and/or conversations) associated with the trauma includes efforts to avoid activities, places or people that provoke recollection of the trauma; feelings of detachment from others; significantly diminished interest or participation in important activities; a restricted ability to experience feelings, such as love; and a sense of a foreshortened future. Increased arousal, or hyperarousal, is characterized by sleep problems, difficulty controlling anger, difficulty concentrating, hypervigilance, and an exaggerated startle response. To receive a diagnosis of PTSD the duration of symptoms must last longer than one month, and the disturbance must cause a significantly major functional impairment. Symptoms alone are not enough to obtain a diagnosis. PTSD is considered acute if symptoms last less than three months, and chronic if duration of symptoms is more than three months. With delayed onset, at least six months have passed since the trauma occurred before the onset of symptoms.

While the DSM-IV-TR (2000) clearly states that traumatic events other than combat can be a precipitant to PTSD (e.g., natural or manmade disasters, sexual assault, physical attack), it was the onslaught of returning combat veterans from Vietnam which compelled clinicians to add this disorder to the manual (Jones & Wessely, 2005; cited in Moore, 1986). Despite the variety of different names for which war-related trauma exposure has been known prior to PTSD (e.g., shell shock, combat fatigue syndrome, catastrophic stress disorder, etc.), it is clear from the variety of research stated that these conditions are referring to what we now term posttraumatic stress disorder (Monahan & Neidel-Greenlee, 2003; van der Kolk, Weisaeth, and van der Hart, 1996). Even as far

back as the Civil War, when combatants experienced paranoia, insomnia, confusion, hysteria, memory problems and aggressive behavior, a retrospective study has conferred that many symptoms that fit within the DSM-IV-TR (2000) criteria (intrusion, avoidance, and hyperarousal) classification of PTSD were diagnosed as *nervous disease* during this era (Pizarro et al., 2006).

PTSD remains the term referred to today in addressing combat trauma in returning veterans from Iraq and Afghanistan. In the Iraq War Clinicians Guide (2004), psychiatric disorders are broken down into three phases for diagnostic consideration. The first phase, or *Immediate* phase, occurs during or immediately following the traumatic event whereby soldiers are described as experiencing “strong emotions, disbelief, numbness, fear, confusion, anxiety, and automatic arousal” (p. 12). Diagnostic considerations here include Acute Stress Disorder, Adjustment Disorders, and premorbid anxiety, mood, and thought disorders. The *Delayed* phase is that occurring approximately one week after the trauma, or in the aftermath of trauma, and consists of the following symptoms: “intrusive thoughts, autonomic arousal, somatic symptoms, grief/mourning, apathy, and social withdrawal” (p. 12). Diagnostic considerations in phase two include PTSD, Substance Abuse, Somatoform disorders, Depression, Bereavement, and other mood disorders. Finally, in the *Chronic* phase, which occurs months to years after the traumatic event, individuals are described as having “disappointment or resentment, sadness, and persistent intrusive symptoms” (p. 12). Combatants experiencing such additional symptomatology are diagnostically considered for PTSD, Dysthymic Disorder, Substance Abuse, chronic effects of toxic exposure, or other mood disorders.

One other diagnostic consideration that must be deliberated under the guise of combat-related trauma is *Disorders of Extreme Stress not Otherwise Specified*, otherwise referred to as *Complex Post-Traumatic Stress Disorder* (DESNOS; Herman, 1992). Although not a formal diagnosis, and therefore not recognized in the current edition of DSM-IV-TR (2000), this category has been proposed as an alternative to Axis II personality disorders for individuals exposed to a multiple series of traumatic events so significant they impact the individual's sense of self. Sequelae include "extreme affect and impulse dysregulation (e.g., rage, suicidality, self destructiveness, and unmodulated sexual activity), pathological dissociation, somatization (including alexithymia), and fundamentally altered beliefs concerning self and relationships" (Ford, 1999, p. 4). Researchers have found that prolonged traumatic circumstances, such as the incessant threat of insurgent attacks among active duty soldiers, are an identifiable risk factor in the development of DESNOS (Iribarren, Prolo, Neagos, & Chiappelli, 2005), and that early childhood trauma, regardless of whether the syndrome occurs on its own or is comorbid with other disorders, is an independent risk factor for the diagnosis (Ford).

DESNOS, or complex PTSD, is of particular interest with regards to diagnosis of returning veterans from the Iraq/Afghanistan war. Several aspects of this war are unique to those preceding it including our all-volunteer force; the inclusion of both male and female soldiers; constant re-deployment with little time in between assignments for physical, mental and spiritual recovery; the urban guerilla warfare; and the ambivalent make-up of the enemy resulting in the necessity of soldiers to be constantly alert even when off-duty. If an acquired hypervigilance due to perpetual fear of death or injury and constant redeployment is a potential risk factor for the development of complex PTSD,

when we include natural combat stressors to the equation such as exposure to extreme heat and cold; sleep deprivation; deafening and continuous noise of detonations and weapons being fired; malnutrition; loyalty conflicts; the horror of war carnage; lack of privacy and personal space; and an inability to forgive or feel forgiven (Figley, 2006), treatment becomes much more complex in nature. Further discussion on resilience/risk factors will be addressed later in this chapter.

#### *Treatment: Then and Now*

During the initial phase of WWI, military psychiatrists were bewildered by the bizarre symptoms they were witnessing among soldiers and were at a loss as to how to go about treatment. Incidence of mental illness had been noted in all prior battles, but the industrial production of artillery barrage and the sustained shell fire with high explosives was blamed for this new epidemic (Jones & Wessely, 2005). Thinking the cause to be organic in nature British neuropathologist, F.W. Mott, believed in the possibility that it was either cerebral poisoning due to carbon monoxide released by the explosive blast that was the cause or, in another popular assumption at the time, that tiny particles of shell from the blasts were causing microscopic lesions in the brain (Herman, 1992; Jones & Wessely; Salmon, 1917; Shephard, 1999). Joseph Babinski was treating cases of shell shock in France during this phase and insisted that shell shock could materialize through the mere suggestion from doctors, or by the patient's auto-suggestion and imitation. Treating shell shock as though it were a disease of the will (van der Kolk et al., 1996), Babinski's interventions were known to be rigid in nature, using the "the full moral

authority of the doctor [in order] to restore men to the Army” (Shephard, p. 34). Needless to say, such treatment methods found great favor from a military standpoint.

About a year into the war physicians began to discover that soldiers who had not been exposed to explosions, and had never been in battle, were experiencing similar symptoms as those who had. F.W. Mott and other medical specialists eventually came to believe in the idea of an emotional etiology. Major Thomas Salmon, a reserve U.S. army doctor and Medical Director of the National Committee for Mental Hygiene, reached a similar conclusion. Salmon had been dispatched to Europe to study British and French methods in treating war neuroses to prepare for American involvement, and upon his return stated:

There is a group of cases in which even the slightest damage to the central nervous system from the direct effects of explosions is exceedingly improbable, the patients being exposed only to conditions to which hundreds of their comrades who develop no symptoms are exposed. In these cases the symptoms, course and outcome correspond with those of the neuroses in civil practice.

(Salmon, 1917, p. 513-514).

Initially, the discovery that shell shock was psychological in nature did nothing to change treatment interventions underway in both England and France. When the U.S. entered the war in the latter part of 1917 doctors did everything possible to achieve the primary treatment objective of the military which was to return ailing soldiers back to the front lines as quickly as possible. One of the key interventions relied on three principles: proximity of treatment to the battlefield, immediacy of response, and the expectation of

recovery (PIE; Jones & Wessely, 2005). Also referred to as *forward psychiatry* by the French, temporary hospitals were set up within ten miles of the front lines – far enough away to distance the sounds of war but close enough whereby patients understood their fellow soldiers were engaged in combat with the enemy. It was believed that if soldiers treated for trauma were removed too far from their units, and the camaraderie, the prognosis for recovery would diminish.

Most soldiers treated in such fashion experienced a brief reprieve from warfare. They were fed three meals a day, allowed time to rest, given sedatives to calm nerves, and encouraged to take physical activity as often as possible (Jones & Wessely, 2005). Along with physiological needs, doctors used persuasion, guilt, ridicule, discipline, severity and patriotism to return the soldier to battle as quickly as possible, with very little psychiatric input (Jones & Wessely). The French claimed in 1919 that 91 percent of their soldiers had been successfully treated within a few days and sent back to the front through a “simple and energetic” psychotherapy administered via forward psychiatry (Jones & Wessely, p. 25). Exactly what form the psychotherapy took was not discussed however, they did admit to the application of electric shocks to nonfunctioning parts of the body occasionally (Jones & Wessely). This use of *faradism* (the application of electric currents) was utilized by several mental health practitioners during the war who still believed the source of shell shock could be located in the physiology of the individual, including the registrar in neurology at Queen Square Dr. Lewis Yealland (Shephard, 1999).



Interventions for U.S. soldiers were both similar and different. In the recommendations filed by Dr. Salmon on his return from Europe in 1917 he states “electrical apparatus is necessary for diagnostic purposes and also for general and local treatment” (p. 534). And from the following excerpt it appears that he considered shell shock to be a willful illness whereby patients, if they so chose, could recover:

The patient must be re-educated in will, thought, feeling and function. Persuasion, a powerful resource, may be employed, directly backed by knowledge on the part of the patient as well as the physician...Hypnotism is valuable as an adjunct to persuasion and as a means of convincing the patient that no organic disease or injury is responsible for his loss of function (p.523).

To incorporate these principles the Americans set up Base Hospital No. 117 in La Fauche, France and found forward psychiatry to be highly effective. But while electrotherapy rooms were utilized, as the war evolved many American interventions began to take on a different tone from those of their allies. For example, from the American perspective re-education could be achieved through occupational therapy with type of instruction based on whether the soldier was bedridden, isolated to the hospital, or allowed outdoor activity (Salmon, 1917). Assignments such as wood cutting, construction of roads, and agricultural endeavors were arranged depending on the patient’s ambulatory state (Jones & Wessely, 2005). Additional resources employed included “psychological analysis, sympathy, [and] encouragement” (Salmon, p. 538) and some patients were supported in their efforts “to bring into active consciousness and expose to critical analysis [of his normal mind] the material automatically suppressed” as

a result of the trauma (Schwab, 1920, p. 668). Art therapy was even used to help patients remember past experiences and learn to live with them instead of using repression (Jones & Wessely, 2005).

Dr. Edward Strecker, assigned as a divisional psychiatrist early in the war writes: Often nothing more elaborate than passive relaxation of flexion and tension plus appropriate suggestion was needed to remove tremors; indeed, many of them disappeared spontaneously. If a paralysis responded at all the passive movement which gradually became active by the imperceptible withdrawal of the assisting hands of the physician, electricity was not employed. If a hysterical deprivation could be reached by suggestive persuasion or argument, such “tricks” in the use of the stethoscope, tongue depressor, mirror, etc. as were in vogue were avoided....Occasionally someone who had made a particularly striking recovery was kept for a few days as a sort of hospital “pet” for the sake of the effect on difficult cases. (Strecker, 1944, p. 395).

All in all, using forward psychiatry, the U.S. boasted a front line return rate between 40 and 70 percent depending on severity of battle, prospect of victory, or potential of rest under safe conditions (Strecker).

Soldiers who could not be returned to the front were evacuated back to the U.S. and eventually admitted to neuropsychiatric wards established in general hospitals located in New York, Massachusetts, Washington D.C., Texas, Iowa, Georgia and California (Strecker, 1944). Soldiers in these facilities were treated with a variety of interventions including persuasion, sympathy, discipline, hypnosis, encouragement,

severity, massage and hydrotherapy, vocational and educational programs, and in many cases, psychotherapy (Read, 1918; Salmon, 1917; Schwab, 1920; Visher & Tartar, 1926). As of June 1919, more than 8,300 soldiers diagnosed as neuropsychiatric cases had returned from overseas, with the total number of soldiers treated with neuropsychiatric disabilities in World War I recorded as 69, 394 (Strecker, 1944)

Many British soldiers suffering from combat-related trauma were not so fortunate in receiving treatment. The British military death penalty was in effect until 1930, and between 1914-1918 it has been estimated that more than 300 men were shot for cowardice relating to shell shock (Taylor-Whiffen, 2006). Britain's Ministry of Defense announced in August of 2006, almost 90 years after the executions took place, that a group pardon for all soldiers had finally been approved by Parliament.

Lessons learned from treating WWI shell shock victims were numerous including the benefits of front line psychiatry (Jones & Wessely, 2005), but there were enormous cost in terms of manpower and financial compensation soon brought about the matter of prevention. The concern of prevention in U.S. military annals is documented in a cable to the U.S. Chief of Staff on July 15, 1918, from General Pershing questioning military efforts in eliminating those unfit for duty:

Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organizations new draft prior to departure for the United States. Psychiatric forces and accommodations here inadequate to handle a greater proportion of mental cases than heretofore arriving, and if less time is taken to organize and train new division,

elimination work should be speeded, stating that much more could be done prior to deployment so as to ensure fewer mental health casualties (Strecker, 1944, p. 404).

While little preventative action could be taken to step up efforts in the final stages of WWI, during the lead up to U.S. involvement in the Second World War political and military forces were hell bent to detect and separate those deemed psychiatrically impaired from engaging in military duty.

Initially, the primary role of American psychiatry in WWII was to focus on prevention, as compared to treatment, through “the detection and separation at the earliest possible time of bad military risks, from a psychiatric point of view, [those] who had somehow slipped past the draft and induction-station medical examiners” (Deutsch, 1944, p. 420). While the role of psychiatry was concerned with induction duties, training, treatment, and disposition, prevention of psychiatric problems was considered to be the most important, albeit least developed, characteristic (Menninger, 1947). So as to further develop this objective, a double screening process was established whereby recruits were first interviewed by medical examiners from their local boards, with individuals of questionable status referred to a medical advisory board (with 584 locations across the U.S.), and individuals who appeared qualified sent on to army induction centers where final screenings took place (Deutsch, 1944). This process was called the Selective Service System, and was part of the Selective Service Act that had been approved by Congress in September of 1940 (Deutsch).

By the Spring of 1943 it was readily apparent from the large numbers of psychiatric casualties being treated for *battle exhaustion* (later referred to as *combat fatigue syndrome*) that screening procedures had failed (Jones & Wessely, 2005). In the

U.S. more than 20,000 soldiers per month were being admitted for neuropsychiatric disorders, with numbers reaching a climax of 31,000 in August of 1943 (Jones & Wessely, 2005). One problem with the screening procedures was the acute shortage of trained psychiatrists available. When the war began in 1941 there were less than 3,500 psychiatrists in the entire U.S. (Deutsch, 1944; Crammer, 1999) making the requirements of the Selective Service System extremely difficult to meet. Recognizing this, and in an attempt to salvage the bare necessities, the double screening process was abandoned in favor of a two-minute psychiatric interview at induction centers. This preliminary examination was to offer valuable information pertaining to a recruit's intelligence, work history, and neurological organization (Reynolds, 1942) but as many as 200 men were showing up per day to be examined by a single psychiatrist, making the entire effort nothing more than a charade (Deutsch).

Additional attempts at using preventative measures to keep the troops mentally strong included the use of psychiatric techniques to build morale as described by Deutsch (1944). He writes that several psychiatrists at the Aberdeen Proving Ground in Maryland offered a series of weekly lectures on mental hygiene for new soldiers during their first few days of basic training. The lectures presented included issues surrounding "natural resentment of having to participate in army life and regimentation, the problem of fear, and so on" (p. 434). New soldiers were encouraged to talk about personal troubles and ask questions about army routine and function. The lectures were set up under controlled conditions, with one company at a time utilizing the format. After comparing results from a 9 month period it was discovered that soldiers who had received the series of lectures spent more time in training, were sick less often, were less likely to be accused of

malingering, and appeared, as a group, to have much greater morale than soldiers who had not been exposed.

Nothing was considered worse for morale than the evacuation of soldiers from the front lines for psychiatric reasons, thus much effort was placed in the debriefing of soldiers following the day's operations. Introduced during WWII by General S. L. Marshall who was serving as the chief historian of the U.S. Army, *Group Debriefing* was utilized to help troops develop a narrative of the days events, and was believed to have significant emotional benefits (Bisson, McFarlane, & Rose, 2000). Marshall believed that debriefing needed to be held in theatre as soon as possible after the day's battle, and suggested that 7 hours were needed to fully appreciate individuals' experiences.

When debriefing failed, and soldiers were brought to evacuation hospitals near front lines, treatment resumed where it had left off in WWI with the idea that "three hots and a cot" would help in recovery efforts. The term combat "fatigue" was useful in that it implied that soldiers were simply fatigued from battle and needed a bit of rest and replenishment (Jones & Wessely, 2005). Agreeable to this concept, Captain F. R. Hanson, a psychiatrist assigned to the 48<sup>th</sup> Surgical Hospital located 2 miles outside of Gafsa, Tunisia, ordered all patients suffering from combat fatigue to be given large doses of barbiturates, placed on complete bed rest, and awakened only to eat and use the latrine (Monahan & Neidel-Greenlee, 2003). As in WWI suggestive techniques and little tricks were used to encourage soldiers to return to the front, with more emphasis on repressing combat stress reaction than treating it (Jones & Wessely). Monahan & Neidel-Greenlee write that in Gafsa, once soldiers were awakened, attractive red-headed army nurse Lieutenant Helen English would be found walking around the tent not even flinching as

heavy artillery bombardment sounded all around them. Soldiers felt that if she could take it, so could they, and some were inspired to return to their units on the front lines.

Soldiers who failed to succumb to PIE treatment for combat-trauma were once again scorned and segregated. Wagner (1946) writes about the psychiatric activities during the Normandy Offensive stating:

As a group the socially and emotionally immature soldiers shrunk from combat with almost feminine despair and indignation – as if the experience were a horrible imposition that no one had a ‘right’ to expect of them...From the point of view of character structure they were neurotic – in their narcissism...from a military perspective they were psychopaths, often poseurs as exemplary garrison soldiers but ...unable to measure up to group requirements in combat.

(p. 356).

With regards to statistical information derived from treatment efficacy and return to duty rates, Needles (1946) states that such data needs to be carefully examined and put into context. He writes

“It is a point of special pride with the authoritarian psychiatrists that they return a large number of patients to duty. The higher command is apparently composed of men impressed by figures and much too busy to look behind them and inquire into their meaning...The point is that men can be returned to duty *regardless of their psychiatric condition*” (p.171-172).

Needles goes on to conclude that many times it is the commanding officer who determines which soldiers return to the front lines and psychiatrists have little say in the matter. “...so these men were intent on declaring higher and higher dividends from their

commands. How many sick men were returned to active combat or to other duties to further the aspirations of these ambitious leaders, it is distressing to contemplate” (p.172).

In support of Needles concerns, Monahan & Neidel-Greenlee (2003) write that in Gafsa, between September 9<sup>th</sup> and December 9<sup>th</sup>, 1943, only 26 percent of battle fatigue cases were returned to duty from a total of 2,749 cases. The remaining 74 percent were evacuated out of the combat zone and given a “Section 8” – the psychiatric designation for discharge from the armed forces. In other areas the numbers of soldiers suffering from neuropsychiatric troubles were much higher. “Exposed to almost constant bombing, shelling, and combat, 4,786 cases occurred at Anzio and Cassino between January and April, 1944” (Monahan & Neidel-Greenlee, p.297). Soldiers who were evacuated to base hospitals experienced similar interventions from WWI such as exposure to vocational and occupational therapies.

Group psychotherapy was also utilized both during and after WWII. In their 20-year follow-up study examining persistent stress reaction after combat in WWII combat veterans, Archibald and Tuddenham (1965) write “our hypothesis is simple: combat was experienced in a group setting and can best be *abreacted* in one” (p.480). Given the shortage of psychiatrists and mental health professionals, and the need to treat large numbers of servicemen, the wider use of group psychotherapy became a lasting clinical development of the war (Jones & Wessely, 2005).

With roots going back to ancient times, the term abreaction in the late decades of the nineteenth century was introduced by Joseph Breuer and Sigmund Freud to refer to the emotional release that patients felt after remembering a traumatic experience.

Abreaction was used tentatively during WWI, but many individuals argued against its use



in revealing unconscious processes (Jones & Wessely, 2005) including Carl Jung, who believed instead in the importance of “re-integration” or “re-synthesis” of the traumatic memory (Cardena, Maldonado, van der Hart, & Spiegel, 2000, p. 265). But during WWII even a few British psychiatrists considered abreaction to be “an appropriate intervention in resistant cases,” with “focus on the active suppression of the natural fears of battle remain[ing] popular during World War II” (Jones & Wessely, p.98). American psychiatrists used both hypnosis and narcotherapy (insulin, ether, sodium-amytal, and sodium pentothal) to assist with abreaction (Cardena et al.) with varying results.

One of the most significant treatment outcomes of WWII was the recognition given to the psychiatric component in the development of certain somatic complaints (Deutsch, 1944). Peptic ulcers, one of the most serious illnesses in the armed forces, were approached during WWII from a functional, as opposed to organic, perspective (Deutsch). This significant change was associated with several studies examining the causation of gastrointestinal disorders, cardiac syndromes, and dyspepsia (Jones & Wessely, 2005). In support of these early findings, a recent study examining the association between physician-diagnosed medical disorders and combat-related trauma in 605 male veterans from WWII and the Korean War, showed that trauma symptoms were associated with increased onset of arterial, lower gastrointestinal, dermatologic, and musculoskeletal disorders (Schnurr, Avron III, & Paris, 2000).

The Second World War was one of the bloodiest in history and lasted far longer in duration than WWI. Over 16 million U.S. soldiers served world-wide, and more than 290,000 died as a result of combat (Office Of Public Affairs, 2003). The National Center of Traumatic Stress Disorders estimates that one of every 20 WWII veterans suffered

symptoms such as nightmares, flashbacks and irritability on their return. It is projected that approximately 400,000 soldiers were eventually evacuated back to the U.S. for psychiatric problems (Goldstein, 2001), and according to 2006 data from the U.S. Department of Veterans Affairs, 25,000 World War II veterans are still receiving compensation for PTSD related symptoms. During the war therapists fought to establish credibility with their medical counterparts and military peers, with their main objective to treat soldiers as effectively as possible in the limited time available. Unfortunately, many military psychiatrists were conflicted between their allegiance to the “nation to see that its rights are protected and that every soldier does his utmost...[and] to psychiatric truth to see that the mentally ill and the under-endowed are not required to do more than they are capable of” (Needles, 1946, p. 168). While the ability of military psychiatrists to perform their job on behalf of the soldiers they served was questioned by many who felt Army psychiatry was in a state of regression (Needles), additional critiques that poured in after the war complained about the shortage of psychiatrists during the conflict and their basic lack of training.

In one such critique Koontz (1947) wrote an article for *Military Surgeon* entitled *Has Psychiatry failed us in World War II?* He stated that, while statistics were still not readily available, it appeared that the percentage of psychiatric casualties was much greater during the Second World War than during WWI and declared that the lack of available experienced psychiatrists at induction centers around the U.S. was a major causative factor. He was not alone in his observations. In research conducted by the Navy in 1947, Raines examined the Navy’s screening attempts, or lack thereof, as a possible explanation for inconsistencies in the numbers of psychiatric casualties reported. In one

particular case he discovered that three transports had been sunk within a short time and distance from each other but all three reported different numbers of psychiatric casualties from very low to very high. A study of service records revealed that the transport with the highest number of casualties had received the least intensive vetting of the three, whereas the transport with the lowest number of casualties had been subjected to the most rigorous. Raines reported that the short supply of psychiatrists (645 at the peak) contributed to the inconsistencies in screening. Not only did Raines believe the Navy could have used double the psychiatric manpower, he also reported that out of 95 regular Navy psychiatrists still commissioned at the end of the war, all but 17 had received their training “on the job,” with no military psychiatric experience prior to their deployment.

In 1950 The U.S. was caught off guard by the invasion of South Korea, as were her Western allies. Forces stationed in Japan under the command of General Douglas MacArthur immediately transferred munitions to the South Korean army and used air cover to protect evacuation of U.S. citizens (Korean War, 2007). When U.S. soldiers finally engaged in battle they experienced extreme difficulties with the cold (recorded as low as -27 degrees Celsius), confusion in identifying the enemy (guerrilla fighters were known to infiltrate groups of refugees), and the massacre of tens of thousand of alleged communist sympathizers by the South Korean military during the Daejeon, Jeju, and Nogun-ri massacres (Korean War, 2007).

At the start of the Korean conflict psychiatrists in the U.S. military came to believe that screening could be a reliable means of prevention if the appropriate variables were measured. Jones and Wessely (2005) noted that screening efforts during this conflict focused on the measuring of intelligence, which was considered fairly reliable, as

opposed to trying to detect psychological vulnerabilities as in past wars. As a consequence, neuropsychiatric rejections fell from the 7 percent recorded during the Second World War to 2 percent in the Korean conflict. They report, however, that soldiers excluded because of mental deficiencies actually rose from 4 percent to 13 percent because of the intelligence testing.

It is difficult to determine if efforts to screen soldiers prior to the Korean War were of value. In a study examining psychiatry during the conflict, Ritchie (2002) noted significantly high numbers of psychiatric casualties among American troops during the initial months; 250 per 1000. Upon further investigation it was discovered that not only were psychiatric casualties very high during June through September of 1950, Jones and Wessely (2005) report a study done by Reister (1973) indicating that psychiatric battle casualties rose as high as 460 per 1,000 troops between June of 1950 through November of 1951. Casualty returns and psychiatric reports were analyzed, with results indicating that the high number of psychiatric casualties co-conspired with two phases of the war in which combat was particularly intense (Jones and Palmer, 2000), with overall rates at the end of the war much lower (37 per 1,000).

After the first wave of psychiatric casualties appeared, the U.S. immediately initiated the principles behind PIE, having learned from past experience that combat-related trauma seemed to respond to treatment the sooner it was addressed. By December of 1950 a three-tier system of treatment including forward psychiatry, hospitals in Korea, and two convalescent units in Japan were in place (Jones & Wesseley, 2005; Ritchie, 2002). But on very few occasions was treatment anything more than an attempt to return soldiers back to front lines as soon as possible. In an examination of psychiatric

procedures in the Korean War, psychiatrist Robert Edwards and neuropsychiatric consultant Donald Peterson write:

We have concluded that in fighting a war it is impracticable as well as futile to commit our limited facilities to attempts at long-term therapy. The demands of war on the citizen-soldier are current, pressing, and allow no time-out for alterations in his basic personality. (1954, p. 724).

Once the principles of forward psychiatry were implemented in Korea, return rate statistics as high as 50 to 70 percent were reported (Ritchie, 2002), but once again such data needs to be approached cautiously as statistical notation pertaining to efficacy was not a primary goal of therapists, but more so commanding officers. To date the U.S. Department of Veterans Affairs (2006) reports that almost 11,000 Korean War veterans are still receiving compensation for PTSD related symptoms.

In a study examining the techniques of combat psychotherapy as they evolved during World War I, World War II, and the Korean War, Glass (1954) stated they all involved four basic ideals: 1. Treatment of combat soldiers as close to the front line as possible; 2. Treatment that was simple and brief; 3. The creation of a positive therapeutic environment that would motivate soldiers towards recovery; 4. Specific focus of the psychiatrist on the overall needs of the combat group as compared to the individual needs of soldiers. During the Vietnam War many of these techniques were integrated into treatment intervention, and initial feedback was extremely positive with regards to efficacy. But as the war wound down and veterans began to reintegrate back into American society a new phenomenon was recorded: delayed onset PTSD.

In the initial stages of the war, military psychiatrists fell back on forward psychiatry to treat combat exhaustion which in Vietnam included the “standard technique which keeps an anxious, fatigued soldier near the fighting, gives him a few day rest and relies on group pressure and morale to keep him intact when he is sent back to his unit” (DeFazio, 1978, p. 30). The acronym BICEPS (brevity, immediacy, centrality, expectancy, proximity, simplicity) was introduced as the newer version of PIE, and utilized with service members unable to function because of combat stress reaction. Psychiatrists believed that forward psychiatry, when combined with frequent periods of rest and replenishment, a general lack of prolonged exposure to shelling and bombardment, and a limited tour of duty (365 days), were the key to preliminary statistics indicating great success; psychiatric casualty rates of 12 per 1000 (DeFazio). The military believed it was doing all it could to fight combat-related trauma and early figures brought about much optimism and conviction that acute combat reaction had been alleviated.

Such figures continued to be recorded at a steady rate, and statistics compiled in the early and middle phases of the war sustained beliefs that combat exhaustion was indeed under control. In the latter phase of the war the numbers of evacuated psychiatric casualties continued to be extremely low, but simultaneously extremely disturbing observations began to take root. Heavy drug use among soldiers was increasing, a heightened racial tension could be detected, and a drop in military discipline was becoming extremely apparent culminating in the widespread practice of assaulting, or *fragging* (killing someone with a fragmentation grenade), military officers (Bey, 2006; Kormos, 1978). The classic, military psychiatric way of dealing with the treatment and prevention of combat trauma, and interventions used with more traditional forms of

psychiatric disorders, seemed poorly suited for dealing with these unique issues that were emerging at the end of the conflict (Kormos).

It appears that optimism concerning the low rates of psychiatric casualties can be equated to the initial comprehension that combat-related trauma was going to be of the same etiology and pathology in the Vietnam War as it had been in former conflicts, and soldiers seeking aid would do so quickly or in the immediate aftermath (Figley, 1978). Unfortunately, other forms of psychopathology including drug abuse, insubordination, and fragging were all being seen at unprecedented levels, and it would take some time before the true nature of what had transpired in Indochina began to manifest within the psyche of returning combat veterans.

Post Vietnam there began an inundation of research studies concerned with the psychological effects of combat and potential treatment paradigms. But these studies did not originate through military or medical channels, instead, they stemmed from the “organized effects of soldiers disaffected from war” (Herman, 1992, p. 26). Hundreds of informal *rap groups* were formed among veterans who were looking for help with their symptoms while at the same time trying to raise awareness of the effects of combat. As the groups increased in numbers and strength their political influence became significant, resulting in the formation of Operation Outreach through the Veterans Administration, which was staffed by veterans and based upon a peer-counseling model of treatment (Herman, 1992).

During this same period a series of studies, which were usually small in scale and lacked control groups, were published that identified an increasing number of soldiers who were starting to blame their symptoms on difficulties with readjustment (Jones &

Wessely, 2005). Charles Figley (1978), in a review of the research, found considerable evidence that Vietnam veterans differed from their predecessors in five specific ways: 1. General and specific orientations to violence; 2. Psychological symptoms; 3. Symptoms of depression; 4. Political isolation; 5. Adjustment troubles. Chaim Shatan, M.D. writes:

Nine to 60 months after demobilization many veterans begin to 'go through changes.' They notice – often for the first time – growing apathy, alienation, depression, mistrust, cynicism, and expectation of betrayal, as well as difficulty in concentrating, insomnia, restlessness, nightmares, uprootedness, and impatience with almost any situation or relationship. (1978, p. 47)

Armed with the information that combat-related trauma could have delayed symptom onset, a working group of researchers was organized to approach the American Psychiatric Association for the new diagnosis of PTSD to be included in the upcoming edition of the Diagnostic Statistical Manual (DSM-III). The relatively quick incorporation (1980) of PTSD as a medical diagnosis dictated that the cause of the illness was by definition trauma – not heredity or family dynamics – thereby validating veterans' symptomatology and giving way to numerous investigations concerned with prevalence rates among veterans (Jones & Wessely).

To date, the number of studies which have examined frequency, etiology, symptom manifestation, and treatment of PTSD in Vietnam veterans is prolific. While several treatment modalities were used over the early years (e.g., trauma narration and reintegration; group and individual psychotherapy; and various techniques to reduce aggressive actions as well as the effects of shame and guilt), no one particular treatment modality was initially deemed more effective than another. However, it was the aftermath



of Vietnam where the idea of treating the veteran within the *family system* was first suggested as a necessary intervention, and the belief that “the family system has potential for both maintaining and eliminating the disorder” (Stanton & Figley, 1978, p. 283) emerged. Over 3.5 million U.S. soldiers had served in Southeast Asia and more than 57,000 soldiers were killed in battle (Office of Public Affairs, 2003). According to the report of findings from the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990), lifetime prevalence of PTSD is 30.9 percent among male theater veterans and 26.9 percent among females. Other studies have prevalence at even higher rates, and according to 2006 data from the U.S. Department of Veterans Affairs, 179, 713 Vietnam veterans are still receiving compensation for PTSD related symptoms.

In the decade following integration of the diagnosis of PTSD into the DSM III, several treatment modalities became commonplace with regards to combat-related trauma. Psychotherapy was employed with two main objectives in mind - to de-condition anxiety associated with the trauma, and change the way individuals perceived themselves and the way in which they viewed their world by re-establishing personal integrity and control (van der Kolk, Weisaeth, & van der Hart, 1996). Psychotherapy techniques were utilized in both military hospital settings and private institutions throughout the United States, but due to deinstitutionalization whereby the number of psychiatric patients fell from 559,000 in 1955 to 340,000 in 1970 and 132,000 in 1980, treatment, research, and coordination of services became challenging to patients and mental health professionals alike (Birley, 1999).

Practitioners in the 1970's and 1980's actively practiced behavioral and cognitive techniques such as flooding, systematic desensitization (SD), prolonged exposure (PE)

and anxiety management training (AMT)(O'Dwyer, 1999; Rothbaum & Foa, 1996), with varying results. In an analysis of exposure related treatments pertaining to combat veterans, van der Kolk, McFarlane, & van der Hart, (1996) found that “exposure to memories of the trauma is an essential element of effective treatment of PTSD” (p. 434), but went on to caution therapists using this technique that in some cases exposure therapy has been known to lead to complications.

Considering all the treatment modalities centered on improving soldiers mental health status, it is interesting to note that professionals are still struggling with war syndromes such as *Agent Orange* and *Gulf War Syndrome*. *Agent Orange*, a defoliant sprayed on trees during the Vietnam War, has often been associated with somatic complaints among soldiers having served during this time frame. *Gulf War Syndrome* was the diagnosis given to soldiers who were suffering from a compilation of physical, psychological, and neuropsychological symptoms consistent with *chronic fatigue syndrome* (CFS) in the aftermath of the Gulf War conflict. Factors considered as possible links to Gulf War syndrome have included chemical weapons, depleted uranium, infectious diseases, oil well fires, and/or anthrax vaccine given to deploying soldiers. Jones & Wessely (2005) argue that symptoms associated with both Gulf War syndrome and *Agent Orange* should be considered medically unexplained syndromes as they are often categorized by somatic complaints such as fatigue, weakness, headache, sleep problems, muscle aches and joint pain, problems with memory, gastrointestinal symptoms, dizziness, sore throat and dry mouth.

The Department of Veteran's Affairs recently released a list of “presumptive” disability benefits for various groups of veterans, with Vietnam veterans exposed to

Agent Orange now receiving possible service connected compensation for some forms of soft-tissue sarcoma, Hodgkin's disease, multiple myeloma, respiratory cancers (lung, bronchus, larynx, trachea), non-Hodgkin's lymphoma, prostate cancer, chronic lymphocytic leukemia, and type 2 diabetes (Department of Veteran's Affairs, 02/2007). Similar presumptive disability benefits have been identified for Persian Gulf War veterans with undiagnosed illnesses. For these veterans who served in theatre with a condition at least 10 percent disabling through December 31, 2011 and are experiencing medically unexplained chronic multi-symptom illnesses defined by a cluster of signs or symptoms that have existed for six or more months such as CFS, fibromyalgia, and irritable bowel syndrome eligibility for service connected compensation is now possible (Department of Veteran's Affairs, 02/2007). And any Gulf War veterans who were deployed to the region from August 2, 1990 to July 31, 1991, who are suffering from amyotrophic lateral sclerosis (ALS), are now "encouraged to apply for disability compensation" (Department of Veteran's Affairs, 02/2007).

Searching for possible causation between deployment-related stress and the risk of developing PTSD and/or CFS, researchers conducted a survey of 30,000 Gulf War veterans between 1995 and 1997 (Kang, Natelson, Mahan, Lee, and Murphy, 2003). Stressors examined included soldiers involved in direct combat; combatants who had witnessed death; and soldiers forced to wear chemical protective gear or subjected to chemical alarms sounding outside of training. With a response rate of 70 percent, researchers found that while increases in PTSD could be linked to increases in stressor intensity, CFS was related only to the low end of the stress spectrum, leaving researchers to remark "unmeasured factors specific to serving in the Gulf could be responsible for the

high rates of CFS among Gulf War veterans” (p. 146). While researchers were unable to link an increase in deployment-related stress to increases in CFS, they did find that soldiers complaining of CFS symptoms were more likely to be younger ( $p < 0.001$ ), single ( $p < 0.001$ ), in the enlisted ranks ( $p < 0.001$ ), in the Army or Marines ( $p < 0.001$ ), and in the reserves ( $p < 0.02$ ).

Gulf War Syndrome was, and is, an ongoing concern for soldiers and their families today, especially since the syndrome has been determined nonexistent. The Gulf War however, for the most part has been deemed a success with regards to psychiatric causality rates, and literature discussing treatment outcome has remained positive. Immediate psychiatric casualties were very few and several groundbreaking studies quickly developed guidelines for mental health professionals and others directly affected by the stress of war with hope the principles might limit stress reactions in returning veterans (Ritchie & Owens, 2004). Having learned from prior battles, for the first time the focus of prevention was on community and familial support with regards to reintegration, as compared to individual factors such as IQ and mental health. One such study was conducted by Hobfall et al. (1991), which highlighted the signs and symptoms of combat-related trauma such as guilt, substance abuse, affect regulation, somatic problems, mood disorders, intrusive memories, thought disorders, social isolation, and suicidal ideation, for mental health professionals and others affected by this phenomenon. Possible negative coping pathways were identified along with both individual needs *and* potential familial concerns. Using a true psychosocial approach in an attempt to further prevent war related stressors, authors mapped out community and military

responsibilities including those pertaining to government, schools, support groups, religious organizations and employers.

The Gulf War was the first war shown to Americans via live feed through their television screens, with focus on the soldiers who fought, their families back home, and how we, as Americans, felt about war (Hobfall et al., 1991). New methods of warfare including high-tech fighter jets and computer-guided missiles were featured throughout the conflict, and over 2.3 million servicemen and women were deployed worldwide (Hobfall; Office of Public Affairs, 2003). From a combat standpoint, the war was “won” quickly, having begun with air raids on the morning of January 16<sup>th</sup>, 1991 and ending on February 27<sup>th</sup> 1991 with a cease-fire and liberation of Kuwait. Over 350 battle and in-theatre deaths were reported from the conflict, with just over 450 soldiers treated for non-mortal woundings (Office of Public Affairs, 2003). Since the war, soldiers experiencing PTSD have been reported between 2% and 9% (The Iowa Persian Gulf Study, 1997; Wolfe, Brown, & Kelley, 1993), with 19,356 Gulf War veterans currently receiving compensation for PTSD related symptoms (U.S. Department of Veterans Affairs, 2006). Psychiatrists and mental health professionals appeared to be more prepared to treat combat-related trauma from the Gulf War than in prior conflicts, with treatment options on the home front taking on more of a biopsychosocial approach. When Operation Enduring Freedom (OEF) began in Afghanistan in retaliation of the World Trade Center attacks in October of 2001, followed quickly by Operation Iraqi Freedom (OIF) in March of 2003, mental health professionals assisting in the intervention of combat-related trauma had almost a century of military psychiatric experiences from which to draw.

In the latest issue of the U.S. Army Field Manual (U.S. Army, 2000), guidelines are outlined for small-unit leaders covering management techniques to assist in the prevention, reduction, identification, and treatment of combat stress reactions in soldiers serving in Iraq and Afghanistan. Typical treatment outlined includes the possible confiscation of weaponry and physical restraint, as well as forward psychiatry techniques such as treatment away from the front lines but in range of enemy artillery. Front line treatment for soldiers in Iraq and Afghanistan once again centers on the concept of BICEPS, with treatment offered by Combat Stress Casualty (CSC) teams that coordinate efforts with unit leaders. The manual reads:

Treatment is kept very simple. CSC is not therapy. Psychotherapy is not done.

The goal is to rapidly restore the service member's coping skills so that he functions and returns to duty again. Sleep, food, water, hygiene, encouragement, work details, and confidence-restoring talk are often all that is needed to restore a service member to full operational readiness. (p. 63)

CSC teams normalize soldier's symptoms by informing those affected:

If treated near [your] units, 65 to 85 percent of combat stress casualties [will] return to duty within 1 to 3 days. About 15 to 20 percent more [of you] return to duty in 1 to 2 weeks. Only 5 to 10 percent [of you] are sent home, and these usually have other problems in addition to combat stress reactions. (p. 63)

As implied, the U.S. Military believes that if combat stress patients are evacuated out of theatre few will return to duty, with most of them likely to be permanently disabled (U.S. Army Field Manual, 2000). Therefore, much emphasis is placed on unit cohesion, sharing the burden of battle, and reducing stress so as to prevent combat stress reactions

from forming in the first place. Those affected by combat-trauma are encouraged to think of themselves as “war fighters,” as compared to patients, and are deployed back to their original units as quickly as possible.

In addition to BICEPS and forward psychiatry, the U.S. Army also uses *Critical Event Debriefing* (CED) to lessen the impact of a critical event and to expedite recovery of soldiers involved. An adaptation to Marshall’s Group Debriefing from WWII, CED’s are usually conducted 24 to 72 hours after the event, last from 2 to 3 hours in duration, and occur away from the scene and separate from any operational debriefing that may be occurring at the same time (U.S. Army Field Manual, 2000). Situations warranting a debriefing, according to the manual, include the death of a unit member, death or suffering of noncombatants, the handling of the dead, a serious friendly fire incident, a situation involving a serious error, injustice or atrocity, and an eyewitness account of horrific devastation.

While CED’s are intended to be conducted by a team composed of medical doctors, chaplains, mental health professionals and trained unit members, access to trained professionals is at times difficult. In such cases the manual states that an *After Action Review* (AAR) or *Hotwash* take place under the command of the small-unit leader. The AAR is broken down into six phases: the *Fact Phase* (individual perspectives on their roles); *Thought Phase* (individual’s first thoughts at the scene); *Reaction Phase* (what was the worst thing about the event? What did they think or feel?); *Symptom Phase* (immediate and delayed cognitive, emotional and physical reactions); *Training Phase* (psychoeducational component to normalize reactions); and the *Wrap-Up Phase* (positive

affirmations on actions taken and accessibility of unit commanders to individual soldier's needs) (U.S. Army Field Manual, 2000).

While the concepts and practices of BICEPS and CED take place on the front lines, stressors related to pre-deployment and post-deployment are tackled both overseas and on the home front for preventative purposes. Programs for military personnel including BATTLEMIND and SWAPP (Soldier Wellness Assessment Pilot Program) have been established to better provide soldiers and their families with information pertaining to the impact of deployment on psychological, social-emotional, and behavioral functioning and the preventative aspects of behavioral health care. Several studies examining harmful post war consequences have found that feelings of guilt, emotional withdrawal, and elevated levels of aggression in returning soldiers make it challenging for veterans to fully resume former familial roles (e.g., father, husband, financial provider), with families showing markedly elevated levels of severe and diffuse problems in marital and family adjustment, sleeping patterns, parenting skills, social support, aggressive behaviors and domestic violence (Dirkzwagger, Bramsen, Ader, and van der Ploeg, 2005; Jordan et al., 1992; Sherman, Sautter, Jackson, Lyons, & Han, 2006; Solomon, 1988).

In utilizing this information the U.S. Army Manual (2000) recommends that units set aside time during the last few days before leaving the theater to conduct *End of Tour* debriefings where soldiers have opportunity to discuss what stands out in their memories, good or bad, as they recount operations from pre-deployment to date. Memorial ceremonies and decorations are supposed to occur at this time, along with CSC team debriefings on possible problems soldiers may encounter as they reintegrate into their



family and societal responsibilities. Finally, soldiers are to receive a psychoeducational component normalizing possible combat-related trauma symptomatology and are given a list of resources (e.g., VA Hospitals, Clinics, and Veteran Readjustment Centers) to help them deal with symptoms if they become chronic.

While the U.S. Army Manual (2000) also includes a variety of helpful information pertaining to pre-deployment stressors, and prevention thereof, very few studies to date have empirically researched this phenomenon. One study which examined the relationship between *hardiness* and the development of PTSD among 1,632 male and female Vietnam veterans, found that hardiness demonstrated a direct negative association with PTSD for both genders (King, King, Keane, Fairbank, & Adams, 1998). This is significant in the sense that the term hardiness, for the sake of this study, meant a sense of control over one's life, commitment in terms of the meaning ascribed to one's existence, and openness to viewing change as challenge. Using this meaning, hardiness appears to be a characterological development prior to combat and would imply that individuals of a hardy nature would be much more resourceful in times of stress. The Army's pre-deployment regime of physical fitness training, stress-coping skills training, sleep discipline, and task allocation and management all appear to cater to the concept of hardiness and the belief that the harder one becomes, the less likely they will break down under combat stress.

Treatment modalities on the front lines have evolved considerably to date, and so have the mental health interventions that take place on the home front. According to the U.S. Department of Veterans Affairs (2006) specialized PTSD outpatient and inpatient treatment programs are operating in more than 100 VA facilities across the nation.

Outpatient services offer veterans access to education, evaluation and treatment through Partial Hospitalization Programs (case management, counseling, group therapy, education, psychotherapy, vocational, and recreational activities); PTSD Clinical Teams (group and one-to-one evaluation, education, counseling, and psychotherapy); Substance Use PTSD Teams (outpatient education, evaluation, and counseling for the combined problems of PTSD and substance abuse); and Women's Stress Disorder Treatment Teams (group and one-to-one evaluation, counseling, and psychotherapy for issues which include military sexual trauma).

Group treatment for PTSD has received much attention from researchers, but few interventions have undergone rigorous evaluation. In a meta-analysis which synthesized the results from controlled clinical group treatments for PTSD that included psychoeducation, exposure, cognitive restructuring, supportive, and process group therapy, researchers found that all interventions appeared to have a positive outcome on trauma symptomatology, with no one type of therapy consistently improving one particular symptom (Bornstein, 2003). Recognizing that group treatment has become increasingly popular due to the large number of veterans seeking assistance, and a reduction in treatment resources, many researchers continue to examine their efficacy pertaining to PTSD.

Bolton et al. (2004) gathered self-reports from 197 veterans diagnosed with the disorder who had served in Vietnam, Korea, and the Persian Gulf. The veterans participated in three twelve-week cognitive behavioral group therapy modules - Understanding PTSD, Stress Management, and Anger Management, and were assessed during the first week and the last week of each section. Results indicated that following

the first module, Understanding PTSD, veterans reported less distress associated with the re-experiencing of symptoms. After completing Stress Management veterans reported a moderate reduction in depressive symptoms and a slight increase with overall life satisfaction. And after completing Anger Management veterans reported significant decline in reports of recent violent behavior, and improvements in self-reports of overall physical health. While additional research using randomized, controlled trials is warranted, in particular with regards to the efficacy of PTSD group psychotherapy, group intervention continues to be a major component in the treatment of PTSD at VA hospitals and Veteran Readjustment Centers.

In addition, some VA facilities offer veterans suffering from PTSD different types of inpatient programs that provide 24-hr nursing and psychiatric care including Evaluation and Brief Treatment of PTSD Units (evaluation, education and psychotherapy from 14-28 days); PTSD Residential Rehabilitation Programs (evaluation, education counseling, and case management focusing on community and familial integration from 28-90 days); and PTSD Substance Use Programs (evaluations, education, and counseling for substance use problems and PTSD from 14-90 days) (U.S. Department of Veterans Affairs, 2006). While such programs are no doubt effective in assisting with PTSD, this author was not exposed to any in-patient programs such as these at the Houston VAMC, one of the largest in the country, during her eight-month internship. While several outpatient and residential programs were effectively employed, inpatient units used by PTSD veterans were utilized primarily for emergency situations where veterans had become a danger to themselves or others and needed stabilization for a brief period of time.

The primary forms of psychotherapy practiced at VA facilities includes a selection of cognitive behavioral therapies such as behavioral activation, graduated exposure, and anxiety management training, as well as eye movement desensitization and reprocessing (EMDR), and veteran psychoeducation and processing groups. Pharmacotherapy is added to the treatment regiment when necessary with *Selective Serotonin Reuptake Inhibitors* (SSRI's) proving to have the greatest effect on the reduction of all PTSD symptom clusters (Friedman, Davidson, Mellman, & Southwick, 2000). Research supports the combination of pharmacotherapy and psychotherapy in creating a positive effect in the majority of patients treated for combat-related PTSD (Bleich, Siegel, & Lerer, 1986).

The development of psychopharmacological drugs over the past several years has been influenced, in part, by substantial increases in research examining the physiological and neurobiological correlations to PTSD. Repetitive trauma has been known to impair the development of higher level brain functioning, which potentially leads to poor impulse control and the consequent inability to modulate emotional arousal (Perry, 1997). Poor impulse control and difficulties modulating affect are two significant symptoms associated with PTSD; hence understanding a possible neurobiological etiology is extremely important in furthering our biopsychosocial understanding of this disorder.

At the risk of simplifying the psychobiology of trauma, as explained by van der Kolk (2003), the human brain has developed three interdependent sub-analyzers that detect, amplify, and analyze our internal and external environment; the brain stem, limbic system, and neocortex. Due to the manner in which traumatic memories are imprinted in the sensory and emotional modes they remain stable over time and are unaltered by life

experiences; can be triggered by reminders; and victims cannot articulate thoughts and feelings associated with the trauma. Traumatized individuals have a difficult time evaluating sensory stimuli and mobilizing appropriate levels of physiological arousal because they misinterpret innocuous stimuli. They have low levels of serum cortisol which functions as the “anti stress hormone” (p. 183), and researchers believe that the central nervous system is unable to synthesize the sensations related to the traumatic memory into an integrated semantic memory. In other words, the body keeps score despite individual difficulty in narration and/or memory.

Based on studies of the effects of stress on animals, together with emerging work in the clinical neuroscience of PTSD, researchers Vermetten and Bremner (2002) give us a working model for a neural circuitry of anxiety and fear which they suggest is also applicable to PTSD. In this model they discuss several neurological features which must be in place in order for the brain to process trauma, including the fact that individuals must be able to incorporate their experiences into a cognitive appraisal of the traumatic event. If they are unable to cognitively appraise the traumatic event they will be unable to process it. The authors define the critical brain structures involved in mediating anxiety and fear behavior as the locus coeruleus, hippocampus, amygdala, prefrontal cortex, thalamus and hypothalamus, and periaqueductal gray.

Additional neuroanatomical effects, or *Biomarkers*, of trauma currently being studied include correlation between PTSD and smaller hippocampal volume (Gilbertson et al., 2002) and alterations of brain structures such as hyperactivation of the amygdala and hyperactivation of the prefrontal cortex (Vermetten and Bremner, 2002). Biomarkers, as operationalized by the Institute of Medicine (IOM; 2006) are measurable biologic

change that occur prior to a disease, in conjunction with, or as a consequence. Important to note that to date no biomarker can be utilized specifically to diagnose PTSD or assess the risk of its development. However, as the IOM report states, “new and future biomarker studies might help elucidate the way in which genetic, developmental, biologic, psychologic, experiential, and environmental factors interact to influence risk of, vulnerability to, and resistance to PTSD” (p. 36), which would inform future diagnosis and treatment practices.

In examining the neurobiological factors of trauma, one must take into perspective physiological experiences as well. One such retrospective study examined physiological arousal among female veterans, with and without PTSD, and used descriptive statistics to analyze baseline measurements of heart rate, blood pressure, sublingual temperature, and weight (Forneris, Butterfield & Bosworth, 2004). After reviewing the medical records of 92 female veterans, with and without a PTSD diagnosis, results showed that those with PTSD had statistically significantly higher mean baseline heart rates compared with women veterans without PTSD. Additional statistical analyses supported the findings, despite differences in age, race, body mass index, smoking status, or medication use among the veterans, with results supporting previous research linking traumatic war experience with health related problems (Deutsch, 1944; Pizarro et al., 2006; Schnurr, Avron, & Paris, 2000).

The treatment of combat-related trauma has come full circle since WWI when clinicians began arguing between possible organic vs. psychological pathology. We find ourselves almost 100 years later still searching for psychobiological abnormalities in PTSD clients to help inform treatment and minimize psychological duress which explains

why neurobiological testing is sometimes included in multi-method assessments for PTSD along with clinical diagnostic interviews and psychological testing (Keane, 2006). In discerning empirical treatment modalities to date, controlled studies utilizing cognitive behavioral techniques, EMDR, or pharmacotherapy have shown the most promising recent results (van der Kolk, McFarlane, & van der Hart, 1996). CBT treatment in combat veterans is centered on the practice of systematic desensitization as well as possible cognitive distortions of trauma memories and self-actions (Spiegel, 2000). Popular CBT treatments used with PTSD include PE, AMT, stress inoculation training (SIT), and behavioral activation (BA). Additional forms of supportive therapy frequently used include psychoeducation, coping skills, and compensatory strategies.

EMDR is a form of exposure which has a cognitive component and is reported to work by desensitizing the soldier to the original trauma through the processing of the trauma memories. Soldiers are told to evoke the memory of the traumatic incident and picture it in their mind, as well as the feelings, emotions, etc. associated while performing the eye movements (van der Kolk et al., 1996). Specific understanding of how EMDR works is somewhat murky, with some researchers suggesting it is a variant of CBT (Friedman, 2006). Finally, pharmacotherapy utilizing SSRI's has proven to extremely successful in reducing PTSD symptom clusters (Friedman, Davidson, Mellman, & Southwick, 2000) with sertraline hydrochloride (Zoloft), and paroxetine hydrochloride (Paxil), the only two drugs to receive approval from the FDA for the specific treatment of PTSD. MAO inhibitors, tricyclic antidepressants, anticonvulsants, beta-adrenergic blockers, alpha<sup>2</sup>-adrenergic agonists and benzodiazepines are also utilized in the treatment of PTSD symptoms with varying results.

Matters concerning the high comorbidity of mood, dissociative, and anxiety disorders, substance abuse, and character pathology associated with PTSD make the psychiatric diagnosis and ensuing treatment extremely challenging. Kulka et al. (NVVRS, 1990) reported that male veterans with PTSD were more likely than theater veterans without PTSD to show lifetime comorbidity in depressive disorders, panic disorder, generalized anxiety disorder, obsessive disorder, substance abuse/dependence, and antisocial personality disorder. Studies such as this confirm that combat-related trauma affects our soldiers on every level – biological, psychological, social, and spiritual. Trauma literature suggests that in helping patients regain a sense of safety in their bodies, and allowing them to complete the unfinished past, we will alleviate most traumatic stress sequelae (Van Der Kolk & McFarlane, 1996).

Current military statistics state that we have approximately 150,000 troops based in Iraq and Afghanistan consisting of Active Duty personnel and soldiers serving in Reserve and National Guard units (Figley, 2006). Estimated numbers of soldiers seeking mental health services is between 25 and 35 percent (Figley, 2006; Hoge et al., 2006), with a further 60 percent treatment-avoidant due to fears of stigma and loss of career advancement opportunities (Figley, 2006). The current U.S. Department of Defense (DOD) Roster of Recent War Veterans (2006) states that since 2002, almost 600,000 veterans have left active duty in Iraq and Afghanistan and become eligible for VA health care. Fifty-six percent are Reserve and National Guard, and 44 percent are former Active Duty. Of those veterans who have accessed health care through the VA system since 2002, over 29,000 have been treated, or are currently undergoing treatment, for PTSD. In addition, almost 25,000 have sought treatment for nondependent abuse of drugs; more



than 20,000 have sought treatment for depressive disorders; and over 15,000 have sought treatment for affective psychoses.

Larry Dewey, a prominent psychiatrist educated at Harvard and Yale who has been treating combat-related PTSD for more than 20 years, believes that it is the burden of overwhelming guilt, grieving, loss, and pain that forces men to break down in war and afterwards (2004). While Dewey utilizes several therapeutic modalities in his work including individual and group psychotherapy, pharmacotherapy, psychoeducation, humor, and antidote experiences he writes that the biggest obstacle he had to defeat in becoming an effective listener for his veterans was the understanding that he, himself, was just as capable of committing the same horrific acts as his patients given the right circumstances. In coming to terms with this he was able to walk the trenches of the “darkest pit of therapy” with his veterans without fear of what he would find in himself (p.72). He writes what his veterans have taught him over the years about effective treatment:

Combatants are often left with deep burdens of guilt and traumatic grief. They have buried their feelings and memories in order to survive emotionally. Their sleep is disturbed constantly by grim nightmares, and their attention and thinking distracted by the intrusion of the grotesque images of war. All these things tend to drive them towards isolation and silence, or ‘bunkering up’ as combatants often phrase it. Successful therapy involves sharing and honesty, mutual trust and support, understanding the past and limiting its power to control the present and shape the future. For many vets, choosing therapy means choosing to live a full life again despite the pain of the past. (p.113)

### *Risk and Protective Factors*

Perplexed by the knowledge that many soldiers exposed to combat-related trauma do not go on to develop symptomatology, researchers throughout the decades have continuously attempted to identify risk and protective factors associated with its pathology. Researchers have discovered that the development of PTSD is a complex dance between premorbid, morbid, and post morbid factors associated with the traumatic event, and individual constitution and environment.

From a premorbid stance, age, gender, race, intelligence, education, psychiatric history, early traumatization, and lower socioeconomic status have all been identified as risk factors for the development of PTSD (Brewin, Andrews, & Valentine, 2000; Deutsch, 1944; Kulka et al., 1990; Pizarro et al., 2006). Studies have shown that younger aged soldiers pose a higher mortality risk during enlistment as well as higher comorbidity in nervous and physical disease, employment difficulties, substance abuse problems, and difficulties in social relationships upon reintegration (Harmless, 1990; Pizarro et al.). On the other hand, the aging process can complicate the individual's ability to effectively cope with the symptoms of trauma (Bramsen & van der Ploeg, 1999; Lipton and Schaffer, 1986), with additional research suggesting that as veteran's age, their ability to fend-off traumatic memories associated with war service also occurs, leading to possible diagnoses of delayed onset PTSD (Aarts & Op den Velde, 1996; Herrmann, 1994; Solomon and Mikulincer, 2006).

From a gender, education, psychiatric history, previous trauma, socioeconomic, intelligence, and early traumatization perspective, Brewin et al. (2000) presented a series

of meta-analyses of 77 research studies yielding effect sizes for a variety of risk factors comparing civilian and combat-related PTSD, of which all the above were incorporated. Civilian trauma included individuals who had been victims of crime, natural disasters, motor vehicle accidents, terrorist attacks and mixed traumas, whereas military trauma included samples of service personnel present in a war zone, combat, or imprisonment. The meta-analyses revealed that gender effect was nonexistent among combat veterans, but substantial among civilians. While gender information was only available in two of the military studies, and must therefore be interpreted with caution, the NVVRS (Kulka et al., 1990) actually reported lower rates of PTSD in female Vietnam War veterans (8.9 %) than in male Vietnam War veterans (15.2%). In contrast to both of these studies, Kang et al. (2003) found that women veterans who served in the Gulf War were more likely than male veterans to screen positive for likelihood of PTSD. In 2005, Kang et al. examined both female and male exposure to sexual assault and sexual harassment and reported equally significant increases in PTSD associated with sexual assault in *both* female and male Gulf War veterans.

The Brewin et al. (2000) meta-analyses also revealed that younger age at time of trauma, lack of education, childhood adversity, trauma severity, and lack of social support all demonstrated stronger effect sizes in military samples than civilian samples, but the researchers concede that a reason for this may be due to the possibility that military samples are more likely to contain individuals suffering from chronic PTSD than civilian samples, as these risk factors are considered predictors of chronicity. Minority status was found to be an issue in two of the military studies examined but, once

exposure to trauma was controlled for, the role of race in combat was found to no longer be significant. This finding is supported by several additional studies whereby results indicate minority status alone is not a risk factor for the development of combat-related PTSD (Friedman, Schnurr, Sengupta, Holmes, & Ashcraft, 2004; Penk et al., 1989; Trent, Rushlau, Munley, Bloem, & Driesenga, 2000) or the manifestation of symptoms (Frueh, Elhai, Monnier, Hamner, & Knapp, 2004). Even in those studies which have found ethnicity to be a risk factor in the development of PTSD, pre-existing conditions, differential rates of traumatic stressors, psychosocial factors (i.e., racial/ethnic discrimination and alienation), and sociocultural influences (i.e., stoicism and normalization of stress, alexithymia, and fatalism) are suggested as possible mediators (Frueh, Brady, & de Arellano, 1998; Ruef, Litz, and Schlenger, 2000).

A risk factor worth mentioning, but seldom addressed in the literature, relates to category of soldier at war. A regular active duty U. S. soldier rotates back to military bases where combat-related trauma symptoms can be monitored and addressed. National Guard members do not experience this practice. Instead, they often return home to a family ill equipped to deal with their symptoms, thrusting the family system into crisis. In addition, while regular soldiers receive mental health benefits indefinitely through the VA, National Guard members called to active duty by the President receive free coverage for two years maximum following their service, unless they are approved for a VA PTSD disability claim. Evidence that the illness was a direct result of active duty service must be presented, and the claim must be made within the two-year window. The only exception is if the Guard member is discharged or released from service as a result of

PTSD, in which case they will receive coverage indefinitely. As delayed onset PTSD is a factor to be reckoned with, this means that National Guard members are at risk not only with regards to symptom detection, but in treatment and recovery as well. This information is extremely significant considering the make up of current veterans returning from Iraq and Afghanistan eligible for VA healthcare, which is 56 percent Reserve and National Guard members and 44 percent Former Active Duty personnel (DOD, 2006).

In examination of morbid factors leading to development of PTSD, combat exposure is considered to be one of the primary risk factors (Ford, 1999; Hoge et al., 2004; Kang et al., 2003; Pizarro et al., 2006). Studies for the most part have determined that the greater the degree or severity of combat exposure, the greater the probability of developing combat-related trauma, and the longer the duration of symptoms (Engdahl, Dikel, Eberly, & Blank, 1997; Hoge et al; Kang et al.; Raphael & Wooding, 2004). But there is no one preexisting personality trait or disposition that makes certain people more likely to become combat stress casualties sooner than others (Gifford, 2006), and anyone can break under the stress of combat (Brill & Bebe, 1952). This was realized as early as 1917 when researchers Grafton Elliot Smith and T H Pear wrote:

The war has shown us one indisputable fact, that a psychoneurosis may be produced in almost anyone if only his environment be made “difficult” enough for him. It has warned us that the pessimistic, helpless appeal to heredity, so common in the case of insanity [no longer suffices]. In the causation of the

psychoneuroses, heredity undoubtedly counts, but social and material environment count infinitely more. (p. 52)

Supporting this theory, eighty-seven years later, is a longitudinal study of co-twin control analysis of the Vietnam Era Twin Registry analyzing the continuing role of combat exposure (i.e., trauma severity) on the persistence and chronicity of PTSD. Researchers stated that after 25 years PTSD symptoms continued to be elevated in those twins exposed to the highest levels of combat (Roy-Byrne et al., 2004). While the effect diminished over time, the researchers report there is little evidence to suggest a shared genetic vulnerability between combat and PTSD suggesting that combat exposure, as compared to possible inherent factors, was the primary causal dynamic in the development of the disorder.

For additional information pertaining to factors operating during or after the trauma in the development of PTSD, attention is again directed to the Brewin et al. meta-analyses (2000). While pre-trauma factors, as discussed, had rather modest effect sizes overall, trauma severity and additional life stress were shown to have somewhat stronger effects. However, according to the meta-analyses, a leading post-trauma risk factor in the development of PTSD was found to be lack of social support. These results concur with several studies reviewing such variables, including research done by King et al. (1998) examining social support and postwar stressful life events as predictors of the development of PTSD in 1,632 Vietnam theatre veterans. From a risk perspective, the study found that effects of postwar stressful life events (i.e., job interruption, legal or financial difficulties, marital interruptions, criminal victimization, death of a child or a

relative) were found to be a significant predictor of PTSD. The authors note that stressful life events appear to “deplete social sources, which, in turn, could exacerbate PTSD symptomatology” (p.431). From a preventative perspective the study reported that structural social support (e.g., number of groups and organizations in which veterans belonged) predicted functional social support (perceived emotional sustenance), resulting in functional social support having the largest total mediation effect on PTSD for both male and female veterans.

Other studies support the importance of social and familial support, especially at homecoming, as preventative factors in the development of PTSD symptoms (Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; Neria, Solomon, & Dekel, 1998; Stretch, 1986). Such research has noted that veterans meeting the criteria for diagnosis of PTSD were found to have extremely low levels of social support upon reintegration when compared with relevant comparison groups of veterans without the disorder.

The King et al. (1998) study on hardiness previously discussed under treatment of combat-related trauma, must also be re-examined under risk and protective factors. Recall the study found that hardiness (i.e., sense of control over one’s life, commitment in terms of the meaning ascribed to one’s existence, openness to viewing change as challenge) demonstrated a direct negative association with PTSD for both female and male veterans. This study is supported by additional research (Gibbs, 1989) which retrospectively examined variables of resilience against the development of PTSD in young soldiers returning from Vietnam. Gibbs found that social aptitude, an active coping style, and a strong perception of individual ability to control their destiny were found to

be significant preventative factors. An active coping style is of particular relevance to combat conditions in which our soldiers find themselves currently. The ambiguity of the enemy often results in frustration at not being able to fight back or punish the people responsible for the death or injury of a fellow soldier. Being able to cope with such uncertainty would surely fair well for the individual and indicate resilience.

The concept of unit cohesion or *Esprit de Corps* (Ritchie et al., 2004) is also considered preventative in nature. In an article including discussion on current combat and operational stress control efforts as well as prevention, Ritchie writes “the belief in the strength of the unit as a whole is a powerful psychological buffer against fear, and this buffer mitigates against negative combat stress reactions” (p. 3). Ritchie also states that education, discipline, and training are considered primary prevention for all service members “and serves to inoculate individuals against exposure to trauma” (pg. 3). Abram Kardiner and Herbert Spiegel also write about esprit de corps in their bestseller *War Stress and Neurotic Illness* (1947), stating “morale level and psychologic casualties are intimately related because morale is determined by the relatedness of the individual to his group. Morale consists of self-respect, group identification, and cooperation with the team. Esprit de corps is a stabilizing factor in many a tense situation” (p. 35).

The importance of unit cohesion was also addressed in research examining the psychiatric symptomatology associated with contemporary peacekeeping among peacekeepers in Somalia (Orsillo, Roemer, Litz, Ehlich, & Friedman, 1998). Investigation of different types of stressors encountered by 3,461 peacekeepers in Somalia who experienced aggressive civilian acts, indicated that exposure to war-zone



related stressors such as dangerous patrols, direct firing upon their units, and ambiguity regarding appropriate responsive actions to take was the most significant variable associated with high rates of PTSD symptomatology, whereas general military honor /cohesion was the most powerful protective factor.

While the military continues to provide debriefings as possible preventative measures in developing trauma, Orsillo et al. (1998) found that debriefing experience was not proven to be a significant predictor on any outcome measures in peacekeepers exposed to traditional war-zone-related stressors. In a further examination of debriefing evolution and outcome, researchers Raphael and Wooding (2004) state that its use in lessening the risk of the development of psychopathology is yet to be established. Quoting two studies (Deahl, Gillham, Thomas, Searle & Srinivasan, 1994; Solomon, Neria & Witztum, 2000) examining the effects of the debriefing of soldiers during the Gulf War, Raphael and Wooding state that no benefits in terms of outcomes was derived. Deahl et al. was specifically interested in debriefing as it pertained to graves duty, and Solomon et al. examined its efficacy in three separate studies of Israeli army soldiers. Solomon et al. go as far as to state that soldiers suffering from combat trauma may actually be harmed by debriefing, as intense anxieties may become further sensitized with little chance to deal with them.

With regards to PIE tactics two studies conducted on the evaluation of frontline treatment of combat stress reaction among Israelis in the Lebanon War suggest strong, positive effects on psychiatric outcomes. The initial study, published in 1986, found that the principles of proximity, immediacy, and expectancy had significant beneficial effects

on soldiers treated as evidenced by lower rates of PTSD and a higher rate of military return to combat units (Solomon & Benbenishty, 1986). Participants were combat stress reaction casualties who either received or did not receive frontline treatment, and matched soldiers who did not experience combat stress reaction. In the 20 year follow up study, Solomon, Shklar & Mikulincer (2006), examined 429 veterans from the initial inquiry and found that, even twenty years after the war, traumatized soldiers who had been subjected to PIE treatment had lower rates of PTSD and psychiatric symptoms, experienced less loneliness, and reported better social functioning than other traumatized soldiers who did not receive frontline treatment. These studies are interesting to note considering that statistics on return to front-line duty after the use of forward psychiatry tactics have always been a subject of contention (Jones & Wessely, 2005).

#### *Civilian vs. Combat-Related Trauma*

From a biopsychosocial point of view, individuals are not equally affected nor are they equally vulnerable to traumatic events. While psychobiological reactions to trauma, as explained by van der Kolk (1996), affect similar parts of the brain stem, limbic system and neocortex in all trauma survivors, discrepancies in individual constitution are unique to each of us and so, therefore, is our response. This is not to say that those experiencing a traumatic event do not undergo similar physiological reactions, because they do.

Whether one is in the battle field and has just experienced the death of a fellow soldier, or a civilian is involved in a traumatic motor vehicle accident which results in the death of a loved one, the situation will rapidly activate adaptive responses which alter individual cognition, mental state, and physiology (i.e., respiration, heart rate, muscle tone) (Perry,

Pollard, Blakley, Baker, & Vigilante, 1995). In this sense our reactions to stressors are “hard wired.” But the subjective way in which we respond to the objective event, or trauma, and interpret the trauma to which we have been exposed, is very much an individualistic phenomenon (Allen, 1995).

This is apparent in the very diagnosis of PTSD, whereby the necessary criteria of intrusive thoughts, avoidance of trauma stimuli, and increased arousal, can all be experienced in a variety of ways yet still result in the diagnosis. Our response and recovery patterns are extremely complex, as can be seen in the prior discussion of risk and resilience factors. Research suggests that premorbid factors relating to the individual, post morbid factors relating to environment, and morbid factors relating to the length, severity and type of trauma incurred are all mutually influential factors that determine the nature, origin, progress, and cause of PTSD.

So in answering the question: how does combat-related trauma differ from other forms of trauma including victims of crime, natural disasters, motor vehicle accidents, and terrorist attacks, perhaps the answer lies not in the neurobiological or physiological factors of trauma, but in individual variables and the event and environmental factors in which the trauma is associated. Whereas civilian trauma can be random and unsuspecting, from a military perspective individual encounters with stressful events are supposed to be anticipated. Soldiers go through rigorous physical fitness training, stress-coping skills training, sleep discipline, and task allocation and management during the pre-deployment stage in order to instill a sense of unit cohesion, mastery, and behavioral response in the face of traumatic war events. But soldiers can never be completely

prepared for the experience of war. Stressors unique to war which include ambiguous enemy fire and attack under the direst of circumstances such as malnutrition, the constant fear of death or injury, and the horror of witnessing war carnage (Figley, 2006), cannot be taught through pre-deployment conditioning.

But because soldiers have endured all the hardships associated with pre-deployment training, unlike civilians, they are expected to manage their responses to traumatic experiences making it all the more difficult for them to seek help. Soldiers are conditioned to believe that any break in mental vigor as a result of a traumatic encounter is not only a reflection of the cohesiveness of the soldier's unit, or lack thereof, it is a moral disgrace that can be prevented if one chooses to do so (Strecker, 1944). As earlier stated, the British military death penalty was in effect until 1930, and between 1914-1918 it has been estimated that more than 300 men were shot for cowardice relating to shell shock (Taylor-Whiffen, 2006). In WWII, aircrew in the Royal Air Force who were labeled as having a *lack of moral fiber* "lost their flying badges, and were sent to a network of not yet diagnosed, neuropsychiatric centers for assessment and treatment. Those who failed to return to operational duty were either discharged from the air force, reduced to the ranks, or transferred to the army" (Jones & Wessely, 2005, p. 97). Today, stigma is still very much associated with mental health treatment for veterans, with as many as 60 percent of returning OIF and OEF members neglecting to seek help due to fears of stigmatization and loss of career opportunities (Figley, 2006).

Referring back to the Brewin et al. (2000) meta-analysis comparing civilian and military risk factors for PTSD, several differences among the cohorts were revealed.

Disparities with regards to age (younger age at exposure to trauma was only a risk factor in the military), gender (gender effect was significant amidst civilian studies but was nonexistent among combat veterans), race (race did not predict PTSD at all in any female samples, but it was indicated as a significant predictor in male military samples prior to controlling for combat exposure), and trauma severity (impact of which was significantly greater among combat veterans than among civilian trauma victims) led researchers to note that findings “clearly point up the heterogeneity of the disorder in different settings and warn against attempts to build a general vulnerability model for all cases of PTSD at this time” (p. 756).

In another study examining chronic Vietnam PTSD with acute civilian PTSD precipitated by a motor vehicle accident, researchers discovered major differences between the two groups with regards to source of referral, age, sex, socioeconomic level, nature and timing of stressor, character of the intrusive and avoidance symptoms, and treatment noncompliance behaviors (Burstein et al., 1988). The researchers concluded that differences were “of sufficient magnitude to call into question the feasibility, at this time, of constructing generalizations regarding PTSD” (p. 245).

Those who treat trauma understand that the nature in which the trauma transpires, and the ecological factors associated with it, can accelerate or ameliorate sequelae. Research indicates that individuals exposed to the battlefield experience are more severely affected by depression, anxiety, interpersonal sensitivity, and somatization than those experiencing civilian terrorism or work and traffic accidents (Amir, Kaplan, & Kotler, 1996). War is a unique arena whereby soldiers can be victims one minute and

executioners the next. Combat veterans are trained to lose their individuality and conditioned to become part of a tight, cohesive, working unit prior to their deployment. Interventions for those exposed to trauma are aggressive and speedy with little time allotted for rest and recovery before soldiers are sent back into the fray of war. As a result they find themselves, once again, vulnerable to the many forms of trauma found in the heat of battle. The stigma associated with the treatment of combat related trauma is powerful; hence many soldiers decide to forgo help. Individual characteristics (Brewin et al., 2000; Burstein et al., 1988), as well as the very nature by which soldiers are exposed to trauma, treated, and reintegrated appears to be poles apart from those experiencing other forms of trauma, which must, at the end of the day, significantly impact treatment intervention.

#### *The Cost of Combat-Related Trauma*

*Shell shock. How many a brief bombardment had its long delayed after-effect in the minds of these survivors. Not then was their evil hour, but now; now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. In the name of civilization these soldiers had been martyred, and it remained for civilization to prove that their martyrdom wasn't a dirty swindle.*

*- Siegfried Sassoon (Quoted in van der Kolk & McFarlane, 1996, p. 24)*

It has been suggested that optimal screening for PTSD symptomatology occur within 3 to 4 months after the soldier has returned from deployment and 6 months after heaviest combat operations (Hoge et al., 2004). Unfortunately, factors unique to the military create a resistance to seeking treatment with veterans concerned about being

labeled as weak or socially undesirable and negatively perceived by peers and leadership. Dr. Charles Hoge, who directed the 2004 research via his position at the Walter Reed Army Institute of Research, has also stated that “the most important thing we can do for service members who have been in combat is to help them understand that the earlier they get help when they need it, the better off they’ll be” (Associated Press, 2004). Helping veterans frame their traumatic experience[s] in such a way that encourages healing, as soon as possible after exposure to the event[s], may have positive consequences.

From a recall and treatment perspective this ideology is pertinent. In layman’s terms, traumatic events wreak havoc with individual ability to recall and make use of the past. In a study examining stability of recall of military hazards in over 2,200 Gulf War veterans, researchers discovered that as veterans’ perceptions of health deteriorated they were more likely to report an increase in traumatic exposures (i.e., smoke from oil-well fires, dismembered bodies, maimed soldiers), encountered during war time (Wessely et al., 2003). Research such as this indicates that memory changes over time and is influenced by psychological status suggesting, in reference to Hoge, that not only is it important that returning veterans receive help as soon as possible for combat-related mental health disorders, but delay in treatment could have a negative and costly impact on physical health matters as well. Physical health is very much an issue in the treatment of PTSD, as seen in comorbidity rates over the years with gastrointestinal disorders, cardio disorders, and musculoskeletal problems (Figley, 2006; Pizarro et al., 2006), and concerns over comorbid high risk behaviors such as smoking, alcohol and drug use, poor diet, and lack of exercise (McFall & Cook, 2006).

The financial costs of delayed treatment with regards to PTSD are significant. According to a New York Times article published in March of 2006 (Satel), based on a report from the Department of Veterans Affairs, the facility is now paying compensation for PTSD to almost twice as many veterans as they did in the year 2000, with an annual cost of \$4.3 billion dollars. What is particularly significant about the report is that the majority of applicants for treatment are not returning soldiers from Iraq and Afghanistan, rather they are Vietnam veterans in their 50's and 60's who are only just now filing for mental health claims from trauma encountered during their service (Satel, 2006). As soldiers from OIF and OEF continue to reintegrate and seek compensation for disabilities suffered while on active duty, the future financial drain on organizations offering PTSD services could be considerable.

There is no doubt that VA facilities will bear the largest burden as returning soldiers begin filing for disability compensation. In a paper discussing the long-term costs of providing veterans with medical care and disability benefits, Harvard University professor Linda Bilmes (2007) projects that disability claims in the Iraq/Afghanistan wars will be much higher than in wars previously fought due to longer lengths in deployment, repeat deployments, and more intense exposure to urban combat (p. 8). Bilmes writes that demand for VA treatment is far exceeding VA anticipation, especially so in the area of mental health care. Quoting veterans' advocate Paul Sullivan, she concludes that PTSD will be one of the top two signature wounds from the Iraq War, and that treatment will be "the most controversial and most expensive" (p. 11).

Naturally, the costs of combat-related trauma extend far beyond monetary considerations. The aftermath of combat-related trauma reverberates within the individual



and spreads like wild fire among family, friends, and society at large. Many individuals seeking assistance gather with others who speak their “language” to exchange stories on common ground. This was observed in the rap groups quickly formed after the Vietnam War – a venue where veterans “retold and relived the traumatic experiences of war” (Herman, 1992, p. 26). Some veterans with PTSD are severely, chronically incapacitated and their social functioning is markedly restricted, whereby repeated hospitalizations over the years may become necessary with ongoing outpatient support (Friedman, Schnurr, & McDonagh-Coyle, 1994). These veterans place a great strain on caregivers, public housing, community support and public mental health services (Friedman et al.). In addition to mental and physical health problems among veterans, studies have pointed to increases in substance abuse and dependence, criminal activity, employment difficulties, and problems with peer and intimate relationships upon reintegration (Harmless, 1990; (McFall & Cook, 2006). In addition, many of the homeless people we encounter throughout our communities and in our cities are veterans suffering from mental health related issues such as those aforementioned.

One of the most prolific areas receiving attention with regards to the costs of PTSD is the impact symptomatology has on family relations. In 1988 Solomon performed a literature review examining harmful post-war consequences pertaining to male Vietnam veterans, finding that feelings of guilt, emotional withdrawal, and elevated levels of aggression in the returning soldier make it difficult for the veteran to fully resume his former roles of father, husband and financial provider. Figley (1978) noted that feelings of detachment and constricted affect also make it difficult for veterans to fully reintegrate into society.

A 2005 quantitative study which was conducted specifically on secondary traumatization in partners and parents of Dutch peacekeeping soldiers also gives us some insight as to the negative sequelae of trauma (Dirkzwager et al., 2005). Secondary traumatization is a recent term employed among mental health practitioners and refers to the stress resulting from caring for, helping, or wanting to help a traumatized person. Dirkzwager et al. found that partners of peacekeepers with post traumatic stress symptoms reported secondary traumatization in the form of increased sleeping and somatic problems, increased negative social support, and judged the marital relationship as less favorable than partners of peacekeepers without the diagnosis.

While differences exist between peacekeeping soldiers and soldiers who experience combat, results are consistent with data collected from previous research among partners of Vietnam and Persian Gulf military veteran populations. One such study conducted interviews with more than 1,200 male Vietnam veterans and 376 of their co-resident partners, and found that families of male veterans with a current PTSD diagnosis showed markedly elevated levels of severe and diffuse problems in marital and family adjustment, parenting skills, and violent behavior (Jordan, et al., 1992). This particular study also examined the mental health issues of partners, finding that they reported lower happiness and life satisfaction scores and higher demoralization scores than partners of veterans without the disorder. In addition, 55 percent of the partners of PTSD veterans stated that at some point they felt “as though they were going to have a nervous breakdown” (p. 922).

An earlier study by Solomon (1988) noted that emotional numbing of responsiveness and reduced involvement in the outside world were two of the most

problematic symptoms for wives of combat veterans suffering from PTSD. Finally, a study conducted during the same time frame examining the effects of combat related trauma on 205 wives of Israeli combat veterans of the 1982 Lebanon war revealed that PTSD was associated with increased psychiatric symptoms in the wives as well as impaired social relations both within the family system and in the wider social network (Solomon et al., 1992). The role of PTSD on marital discord is particularly important today, as over 50 percent of soldiers currently serving in Iraq and Afghanistan are married, with many more in committed, intimate relationships (Monson, 2005).

From a familial perspective, Jordan et al. (1992) also recount that among male theatre veterans with children, over half of those with a PTSD diagnosis described their families as poorest in functioning with regards to adaptability and cohesion, with veterans also reporting higher levels of parenting problems. In addition, children of veterans with PTSD were deemed more likely to have behavioral problems. This is a serious concern considering that 700,000 children in the U.S. have at least one parent deployed overseas on active military duty (Monson, 2005).

Additional statistics relating to possible familial impact of combat-related PTSD from the VA has its limitations, but need not be overlooked. This data informs us that within one year of their return, alcohol abuse in soldiers returning from Afghanistan and Iraq rose seven percent; anger and aggression issues increased ten percent; and soldiers planning on divorcing their spouse rose six percent (cited in Figley, 2006). Alcohol and aggression issues no doubt play a large role in familial dissatisfaction, but data shared in this case is not correlated specifically with combat-related PTSD.

Obviously the impact of PTSD upon the family unit has been documented and substantiated by several researchers and continues to be an ongoing concern among mental health professionals. Both the U.S. Army and the National Guard report the main reason why soldiers are referred to counseling is for couples therapy (Sautter, 2007), suggesting that we need to step up our efforts in this area. With regards to treatment options, couples therapy and family therapy appear to be seriously lacking in available resources within the VA system. While some promising programs for children and families do exist in the military setting, evidence-based programs are quite limited and further research in this area is warranted. The only family intervention program in the VA system at this time is The Support and Family Education (SAFE) Program which has been recently modified (i.e., Operation Enduring Families) to address the specific needs of OEF and OIF populations (American Psychological Association, 2007). The aim of the program is to provide information that will support adults who care for individuals with PTSD, or other mental illness, over an 18-session curriculum. While the VA has recently stated an understanding regarding the necessity to provide family psychoeducational programs within their services, and has implemented programs in Houston, TX, New Orleans, LA and Oklahoma City, OK, at the time of this writing these programs are in their infancy stages, and SAFE has extremely limited access. Presently this author is aware of no other such programs which have come to fruition.

Understanding the individual, familial and societal costs of combat-related trauma informs theory as well as prevention and treatment efforts. Increasing resistance to the war in Iraq and Afghanistan, underscored by the political shift in recent federal elections, is fueled by the media and can have detrimental effects on the psyche of today's returning

soldiers - repeating the history we witnessed in the reintegration of soldiers after Vietnam. As we are confronted with headlines prevalent in newspapers, magazines, and news wire services, and listen to television anchors discuss etiology and pathology pertaining to PTSD, we must never lose sight of the individual, the veteran, from amidst the mayhem. For the veteran suffering from combat-related trauma, their toughest battle begins well after their service has come to an end.

## CHAPTER IV

### WWI - WWII - KOREAN WAR

Mental health professionals are well aware that new ideas with regards to treatment methodology do not occur in a vacuum. To be considered and accepted they must be compatible in some way, shape, or form with existing ideas created through other sciences, technological advancement, economic conditions, political climate and social milieu. This *zeitgeist*, or spirit of the times, is the theme of this chapter, which will examine how such existing ideas influenced treatment, methods, explanations, and outcomes of combat-related trauma in WWI, WWII, and the Korean War. Using a historical developmental approach, this chapter will examine a few of the individuals and events that contributed to changes in our understanding of combat-related trauma. Community impact, expectation, and perception of combat-related trauma during each timeframe will also be explored, and vignettes from the lives of the soldiers who served will be presented so as to appreciate sacrifices made.

#### *World War I*

While scientists argue that evolutionary theory existed for thousands of years prior to Charles Darwin, it was Darwin's systematic recording of the evolution of species in the early 1830's, through his theory of natural selection, which brought him lasting fame and revolutionized the study of biology, philosophy, anthropology and psychology.

While Darwin himself did not believe in any kind of predetermined social order, and was sympathetic to all races and cultures, those who followed him were not so well-disposed (Hergenhahn, 2001). Darwin believed that evolution was natural – those organisms possessing adaptive features survived, and those which did not perished. Unfortunately, many individuals following Darwin took his concepts one step further and the ideas of *Social Darwinism* and *Eugenics* were born. Social Darwinism basically applied Darwin's concept of *survival of the fittest* to society at large, whereby competition between individuals or groups in human societies drives social evolution ("Social Darwinism," 2007) for the betterment of society. Eugenics took this one step further and advocated *selective breeding*. Sir Francis Galton, Darwin's cousin, proposed in 1865 that "couples be scientifically paired and the government pay those possessing desirable characteristics to marry" thereby weeding out weaker members of society so as to strengthen the "human stock" and create healthy, intelligent people, save society's resources, and decrease human suffering (Hergenhahn, p. 267-268; "Social Darwinism").

A comprehensive far-reaching discussion on the evolution of social Darwinism and eugenics is well beyond the scope of this chapter, but their concepts, inclusive of individual differences and determinism, were very much a part of American society at the turn of the twentieth century. American industrialization was in full swing. The expansion of the railroads, a rapidly expanding American banking system, cheap labor, high tariffs, minimal safety regulations, low taxes, and the restricted right of the government to regulate corporations all promoted the efforts of an influential class of entrepreneurs who favored limited government (Jansson, 2005). The industrialists were

born of the belief that anything could be achieved through an ethic of hard work. The inherited moralistic and punitive views of their ancestors were all pervading, wherein “societal problems such as unemployment emanated from moral defects” (Jansson, p. 60).

With large numbers of immigrants moving to urban areas of the United States that were already experiencing systemic problems pertaining to overpopulation, it was easy for affluent industrialists and politicians to apply the principles of social Darwinism and eugenics when looking at problems related to increases in poverty rates and other societal ills. By 1914 approximately 21 million of the total U.S. population of 92 million were immigrants experiencing dangerous working conditions, long hours of labor, and poor compensation (Jansson, 2005). Such labor issues could not be resolved as industrial influences on political reform were formidable and far-reaching. Those incapable of withstanding societal pressures, or deemed “unsuitable” to the social order, spent time in “character building institutions” which included prisons, mental institutions, orphanages, houses of correction, poorhouses, youth homes, and mental hospitals (Jansson, p. 75).

Several individuals and organizations favoring reform worked towards social improvements in the early 1900’s including Jane Addams, Margaret Sanger, Homer Folks, the Charity Organization Society (COS), and even President Theodore Roosevelt once he left political office. While Sanger fell upon intense criticisms, due to her advocacy of certain aspects of eugenics, she was also hailed as a pioneer for women in support of a woman’s choice as to whether or not she would have children (“Margaret Sanger,” 2007). Initially the field of social work was morally driven, with organizations



and workers seeking those deemed “deserving” to receive social support, but in time broader services were offered after in depth assessments determining familial, personal, and community need (Jansson, 2005). As the decade progressed and the American public became more disenchanted with the status quo of political corruption and several health epidemics, progressives began to reform policies pertaining to minority populations, industrial working conditions, political parties, immigration, juveniles, and public health (Jansson).

While many reforms in mental health had taken place in the latter half of the 19<sup>th</sup> century and the beginning years of the 20<sup>th</sup>, the subjects of psychiatry and psychology were still very much in their infant stages, operating on the “fringes of the acknowledged medical establishment, and characterized by a muddle of conflicting theories, diagnoses and treatments” (Holden, 1998). The medical community was very much connected to the scientific model of diagnosis, otherwise referred to as the *medical model*, whereby patients were grouped into specific categories that insinuated scientific report (Weckowicz, 1984). Louis Pasteur’s germ theory of disease in the 1800’s, Francesco Redi’s disproof of abiogenesis (spontaneous generation), and John Snow’s discovery that water itself was not the cause of cholera, eventually all gave support to the idea that physical illness could be prevented. Psychiatry was working hard to establish credibility during this timeframe and encouraged to embrace the medical model with regards to diagnosis, treatment, and possible prevention of mental illness. In the U.S. neuropsychiatry ended its separate existence when it became formally associated with the division of medicine in 1918; an alliance which would last for posterity (Strecker, 1944).

As the founder of psychoanalytic theory, this paper would be remiss if it were not to mention Sigmund Freud's contributions to the treatment of trauma during this period. Born in Moravia in 1856, Freud's exposure to industrialization, determinism, and the medical paradigm were influential in the development of his theoretical models over the years. At the Helmholtz School of Medicine Freud learned to regard individuals as "dynamic systems subject to the laws of nature" (Hall, Lindzey, & Campbell, 1957, p. 32), whereby individuals needed fuel in order to function, much like the first railway locomotives powered by steam and fueled by burning coal. This mechanistic concept is found in Freud's development of instincts which constitute the collective total of psychic energy, or fuel, available to the personality. Freud also believed that psychic energy itself was displaceable. If "one object is not available either by virtue of its absence or by virtue of barriers within the personality, energy can be invested in another object" (Hall et al. p. 40).

Determinism also appears to have influenced Freud's theoretical perspective, in particular his stage theory of development whereby the basic structure of character is established in the early years of infancy and childhood. By the end of the fifth year Freud believed that one's personality was essentially developed, with subsequent growth simply building on the basic structure (Hall et al., 1957). Determinism, arguably, can also be found in Freud's therapeutic method of free association, wherein the analyst allows the patient to talk about anything that comes to mind without restraint until finally they begin discussing early childhood experiences, in which the analyst finds the answers to all their

current symptomatology. As Freud's theories on human behavior continued to develop, his struggle with the medical model became apparent within his writings.

At a very young age Freud decided that he wanted to be a scientist and he went to medical school at the University of Vienna in 1873 to accomplish this goal (Hall et al., 1957). As is apparent in his 1911 letter to Ernest Jones, Freud believed in the early stages of his career that medicine was the origin of psychoanalytic influence: "We are to withstand the big temptation to settle down in our colonies, where we cannot be but strangers, distinguished visitors, and to revert every time to our native country in Medicine, where we find the root of our powers" (Osmond, 1970, p. 276).

But as time evolved Freud became less enchanted with the diagnostic approach which emphasized the examination of that which was conscious and its scientific method to understanding behavior. Instead, he explored the unconscious by distinctively unscientific means – through hypnosis, catharsis, free association, "reminiscences"(memories), and by making the unconscious conscious through interpretation. By 1927, when asked if all analysts should be physicians, he demanded that doctors who wanted to be psychoanalysts "overcome the onesidedness that is fostered in medical schools and should resist the temptation to flirt with endocrinology and the autonomic nervous system" (Osmond, p. 276). It was this aberration from the scientific method, or the medical model, along with initial attempts to reconcile shell shock with the libido principle (trauma theory), that created great unease among many in the military psychiatric community both during WWI and in the immediate aftermath.

In the evolution of trauma theory, Freud initially claimed that every hysteria was the result of a true sexual experience from childhood that could not be integrated into the patient's understanding of the world and was therefore repressed. His patients were primarily females labeled by psychiatry as "hysterics" with symptoms inclusive of dissociation, amnesia, and conversion disorders. Referred to by skeptics in the psychiatric community as Freud's seduction theory, Freud insisted that an early sexual trauma must have occurred because his female patients all recanted reminiscences that were very vivid and full of powerful affect, and left to their own device the memories seemed to emerge as symptoms symbolic of the original experience.

At a later date Freud revised the theory (i.e., infantile sexuality theory), whereby the sexual trauma did not necessarily have to be a real event, but instead could manifest in the form of an unexpressed, socially unacceptable, sexual desire or fantasy. At this stage of the theory's development Freud attested that the repressed, unacceptable, sexual fantasy re-emerged as a symptom(s) which he called a compromise between the unacceptable wish and self/societal norms. Freud used free association, or the talking cure, to build up patient's self-awareness of their unexpressed (unconscious) emotions and meaning behind their symptoms. After the patient remembered the trauma within the therapeutic alliance, and repeated it through transference, Freud believed they were able to come to terms with the trauma experience and undergo a full recovery.

With regards to war neuroses, Holden (1998) reports the Freudian view was that the experience of an all-male force, in a highly charged emotional environment, together with the experience of battle, aroused normally repressed homosexual and sadistic

impulses which eventually led to a neurotic break. Holden later quotes Freud as he gave a more subdued explanation to the Austrian War Ministry on the moral-ethical dilemma facing the soldier:

Psychoanalysis...has taught...that peaceful neuroses can be traced back to disturbances in a person's emotional life. The same explanation has now been generally applied to those suffering from war neuroses...the immediate cause of all war neuroses was a soldier's unconscious inclination to remove himself from the aspects of military service that are dangerous or offensive to his feelings. Fears for his own life, resistance to the command to kill others, revolt against the total suppression of one's personality by superiors were the most important emotional sources that nourished the inclination to shun war. A healthy soldier in whom these emotional motives were to become powerfully and clearly conscious would either desert or report himself sick. But only a small fraction of war neurotics were actually simulators: the emotional impulse against military service that arose in them and drove them to be sick operated in them without their being conscious of it. (p. 30)

Most physicians disagreed with Freud's sexual etiology of war neuroses, but they gave great weight and consideration to the role and function of unconscious processes in the development of shell shock, as well as the importance of the recovery of emotional memories (Jackson, 1994; Shephard, 1999; Stanton, 1999).

While Freud seemed ambiguous as to whether or not psychoanalysis should be considered medical in approach, most interventions designed during WWI to treat combat

neurosis were medical in design, such as faradism and the practice of “3 hot’s and a cot;” both of which looked at the body from a systems perspective. The desire to label, or classify, different forms of mental illnesses for purpose of diagnosis can also be considered medical, or indicative, in manner. While the practice of psychoanalysis was limited among allied forces during WWI (Jones & Wessely, 2005), in the UK the military was so overwhelmed by shell shock casualties and a lack of trained experts who practiced with any consistency that they “gave this disparate collection of neurologists, budding psychoanalysts and anatomical specialists a free hand to treat their puzzling new patients however they liked – anything to get the sick soldiers fighting fit and back to the trenches” (Holden, 1998, p. 15).

In the U.S., once it became apparent that the cause of shell shock was psychic in nature, zeitgeist predicted the debate between traditionalists and progressives. Traditionalists contended that soldiers who developed war related neurosis were of questionable fiber and viewed such individuals as “constitutionally inferior” (Herman, 1992, p. 21). Progressives claimed that combat neurosis was a psychological condition that could occur in any given man, including soldiers of high moral character, and that recovery was possible for the reason that individuals could be reintegrated into society with positive results (Herman). The literature also began to explore this debate through a moral lens. In a paper read as part of a symposium on *Mental Hygiene and the War* before the Third Convention of Societies for Mental Hygiene at the Waldorf-Astoria in New York City, February 5<sup>th</sup>, 1920, Dr. Pearce Bailey spoke about the applicability of the findings of neuropsychiatric examinations in the army to civil problems. He classified

eight different nervous defects experienced by returning combat veterans, and stated that not only were these defects a medical problem, they were a societal problem as well. He believed that war neuroses could not be used as an excuse for soldiers not to return to the battlefield as this would undermine society: “functional nervous disease... [is] to be counted among the most important of the pathological causes of unproductiveness” (p. 305). “Such persons are not only ineffective themselves, but they make others ineffective. It is in them that mental contagion ... spreads with the greatest rapidity” (p. 303).

As soldiers began to return home from battles waged overseas, several organizations stepped to provide services. Literature pertaining to the general duties of the Red Cross Home Service Program gives us great insight as to societal concerns for returning veterans during WWI. Having helped with communication between soldiers and their families as they were serving overseas, and worked to increase national awareness for the needs of military families, the Home Service Program placed great emphasis on assisting veterans with their financial, social and medical difficulties (American Red Cross, 2006). Not only was it this department’s duty to engage the moral support of the soldier’s family during reconstruction, they also made efforts to secure war benefits, engage the veterans in vocational training, bring about a “reasonable and sympathetic attitude on the part of employers,” encourage the public to maintain a productive attitude, and “supply information, encouragement, legal, medical, and business advice, and other service, when acceptable and necessary” (Lakeman, 1918, p. 16).

When soldiers returned to civilian life they were welcomed home as heroes, but as patriotic fever died away and the reality of returning to their original occupations was felt, the readjustments demanded of them were sizeable. While the federal government often provided soldiers with vocational training, sometimes this help was more of a hindrance, especially if the soldiers were unable to create a successful life for themselves afterwards. The following case illustrates these points:

W.S.V. is thirty-five years old and married. He was born in Germany and came to America when very young. He finished grammar school and attended a business school for two years, but did not complete the course because of special disability in mathematics. While in France, he was “shell-shocked” and exhibited a hysterical fugue. He was returned to the front, but was in constant fear and soon thereafter was hospitalized for pain in ears, back, left hip, feet, and head. He remained in hospitals continuously from November, 1918, until discharge from the army in March, 1919.

After discharge from the army, he was given vocational training in building and construction work, estimating and drafting. . . [Before the army he was an unsuccessful bookkeeper at a lumber yard]. “It was kinda hard for me. Then I worked two and a half years as an accountant for a general contractor. I was really incompetent there, for I was a little too slow for the estimating. Then I broke down and went to the hospital.” He has been in hospitals most of time since with



vague symptoms of headache, backache, restlessness, and anxiety. No physical cause has been found for these symptoms.

(Visher & Tartar, 1926, p. 356)

Cases such as this stirred the scientific community into action. Prior to WWI neurologists at the Royal Victoria Hospital in England had no psychiatric or psychological training, and psychiatrists, for the most part, had no neurological training (Read, 1918). In the U.S. the statistics were equally dire. At the 1920 symposium on mental hygiene Dr. Pierce Bailey continued to lambaste those in attendance, stating:

What medical school today, what general hospital, gives any but the most meager and grudging representations to neurology and psychiatry? Indeed, we are so behindhand in these matters that there is a question if American neurology and psychiatry will ever attain the position they should have unless there is established a special foundation for research and teaching ...” (p. 311).

Dr. Bailey made a direct plea to the newly established fields of American psychiatry and neurology to join together with the purpose of establishing a “special foundation for research and teaching” as quickly as possible (p. 311).

Although the intentions of Dr. Bailey were certainly influenced by the ideas of social Darwinism, his plea helped turn individual and organizational attentions to mental health problems in the armed services. With this added support, American psychiatrists were able to detect and treat shell shock casualties with success rates far higher than those of other countries (Strecker, 1944), leading to the creation of additional classes in

social and mental health at the Johns Hopkins School of Hygiene and Public Health in 1920 (Mandell, 2006).

Prior to the First World War, mental illness was often treated by alienists, doctors who worked in asylums, or physicians who had some interest in psychology (Jones & Wessely, 2005). Their expertise was questionable, their training random, and their motives suspicious in the base case. At the time, medical classification of those mentally ill was sub-divided into three categories under the main heading of “feeble-mindedness” – “idiots,” “imbeciles” and “morons” (Jackson, 1999; Turner, 1999), denoting the paternalism of the medical model. During the 1910’s there were few proven medical practices which cured, improved, or prevented mental illness; consequentially many doctors resorted to sterilization to stop such individuals from reproducing (Jackson). By 1922, 18 states had laws permitting sterilization of criminals, the insane, and those mentally defective; directives which were supported by a society and medical establishment that understood mental illness to be a result of intrinsic, pathological factors that were a threat to social welfare (Jackson).

## *WW II*

The horrors of World War I had given a younger generation of Americans a somewhat fatalistic perspective, as John F. Carter writes in September of 1920 for the *Atlanta Monthly*:

We have been forced to live in an atmosphere of “to-morrow we die,” and so, naturally, we drank and were merry. We have seen the rottenness and shortcoming of all governments, even the best and most stable. We have seen

entire social systems overthrown, and our own called in question. In short, we have seen the inherent beastliness of the human race revealed in an infernal apocalypse. (Pg. 61)

Such fatalism replaced the idealism from the turn of the century, and social reform took a back seat to private enterprise, which many believed would bring immeasurable prosperity if left alone by politics (Jansson, 2005). As manufacturing flourished consumer appetite for new products became insatiable, creating an industry-wide boom in automobile manufacturing, woolen goods, silk products, pianos, radios, refrigerators and the like. Along with this new-found material freedom, Americans also became intrigued with social changes occurring in Europe, and began to question conservative attitudes about sex. Contemporary interest in the exploration of sexual liberation and the psyche was the perfect breeding ground for the reintroduction of Freud, and the further development of psychotherapy in the U.S. (Jansson).

Psychiatrists, in the immediate aftermath of WWI, continued in their quest to further understand and treat trauma symptomatology, albeit in the civilian population. While psychoanalysis was utilized primarily by the wealthy, psychiatrists, psychologists, and psychiatric social workers all became enthralled with its concepts in the early part of the twentieth century (Crammer, 1999). Military psychiatry in the 1920's and 1930's hit an impasse along with the conclusion of WWI however, the common usage of the term shell shock within the general populace had created a widespread compassion for those soldiers who had suffered from the disorder both during and after the conflict (Jones & Wessely, 2005). War historians believe that this turnabout occurred partially because of

fictional stories that elevated and empathized with main characters struck with this disorder (Jones & Wessely). Accounts include those in the *Regeneration* trilogy by Pat Barker, *Birdsong* by Sebastian Faulks, and the 1941 Broadway musical *Lady in the Dark* (Jones & Wessely, 2005). But despite public compassion surrounding shell shock, the U.S. military continued to view soldiers with trauma related disorders as possessing a “lack of moral fiber” throughout WWII and the Korean War.

Having made personal sacrifices for the needs of the nation during WWI, many Americans were experimenting with liberal views about sex and freedom of expression, but social Darwinism and the eugenics movement continued to influence a social and political zeitgeist of days gone by. Women had been given the right to vote, but still found themselves unable to access professions deemed male in nature, or receive equal pay. African Americans who had moved north to fill the vacancies left by servicemen during the war suddenly found themselves unemployed as the veterans returned. While many northern politicians had supported emancipation, African Americans encountered race riots and racial segregation upon their relocation from the south where the majority of blacks were still working for white farmers (Jansson, 2005). Immigration also became the subject of intense scrutiny and, with the passing of the Immigration Act of 1924 wherein the objective was to “maintain the ‘racial preponderance of the basic strain of our people,’” a limit of 150,000 immigrants per year was allotted with specific quotas for each nationality (Jansson, p. 167).

Both eugenics and social Darwinism continued to inform social policy throughout the 1920’s and 1930’s, with conservatives seeking to restore American values thought to

be in danger of extinction from liberal attitudes and social reformers. With the onslaught of the great depression, political convictions that welfare issues should not be the concern of the Federal government forced private agencies such as the American Red Cross to address the needs of the poor alone (Jansson, 2005). Convinced that poverty was a result of characterological deviations, not unlike perceptions of mental illness, several social, political, and religious entities ignored cries for help by the unemployed masses until emergency reforms were initiated by Franklin Roosevelt in the mid-1930's.

One movement eventually came to understand that the basic cause of poverty was not emotional, or behavioral, but in fact economic (Deutsch, 1944). Initially the Mental Hygiene Association approached the Great Depression in anecdotal terms, suggesting that “every cloud has a silver lining” and “a man may be down but he's never out” (Deutsch, p. 364). Founded in the early 1900's as the “science of promoting mental health and preventing mental illness through the application of psychiatry and psychology” (“Mental Hygiene,” 2001), mental hygiene had since become involved in almost every nuance of American society with its founder, Clifford Beers, very much at the forefront of the organization's development.

Clifford Beers was a Yale graduate who suddenly, three years after entering into the field of business, suffered a mental breakdown culminating in an attempt at suicide. He spent the next three years in a variety of different mental institutions and experienced “gross brutalities – corporal punishment, restraint in straitjackets, solitary confinement, countless humiliations at the hands of inhuman attendants and indifferent medical officers” (Deutsch , 1944, p. 356). Upon his release Beers wrote an autobiography

detailing his inhumane treatment, pleading with the medical establishment to create a permanent agency for education and reform for the field of mental disease, so others would not be subjected to the horrors he and fellow patients had experienced. *A Mind That Found Itself* (1908), was an instant success and generated positive reviews among prominent psychiatrists, neurologists, social workers, and socially conscious non-professionals (Deutsch). Dr. Adolf Meyer, director of the New York State Psychiatric Institute, suggested to Beers that the term “mental hygiene” be the key phrase of the association, and the National Committee for Mental Hygiene was launched (Deutsch).

The purpose of the mental hygiene movement, as described in their quarterly magazine from 1924, was six-fold; to preserve mental health; prevent mental disorders; raise standards of care and treatment for the mentally ill; provide education on mental health matters; help veterans disabled from the war; and serve as a link between federal, state, and local agencies involved in the mental health movement. The movement had helped prepare the mental health community for psychiatric casualties in WWI through the vision of Dr. Thomas Salmon, the medical director of the National Committee. It also took center stage in the rehabilitation of returning veterans; garnered increased recognition for psychiatric social work; assisted in the founding of the child guidance movement; provided businesses with a “scientific” means of hiring of personnel; and advanced the philosophy of the organization as a political, economic, social, and individual “cure for all” (Deutsch, 1944). By 1943 seventy-eight mental hygiene societies were functioning in thirty-two states, and over thirty countries had their own organizations (Deutsch).

With the commencement of WWII, mental health professionals associated with the mental hygiene movement were encouraged to assist in several areas defined by Deutsch (1944) as:

1. Maintenance and strengthening of morale on the home front;
2. Formulation of techniques for selecting military recruits for the armed forces;
3. Building up of military morale;
4. Rehabilitation of rejected draft registrants and of military men returned to civil life as psychiatric casualties of war;
5. Maintenance of adequate standards in mental hospitals (p. 364)

While the mental health movement was purposeful in its attempts to prepare for the war emergency at hand, military and civil officials were unfavorable to the idea of psychiatric involvement, and still looked at the field of mental health with distrust (Deutsch).

As time progressed the mental hygiene movement and the military establishment began to see common ground with regards to prevention. Understanding combat-trauma to be debilitating to troop morale as well as extremely costly from a monetary standpoint, the military was intent on utilizing every method possible to screen individuals with psychiatric disabilities from entering the war. After getting off to a poor start they requested the help of psychiatrists involved with the mental hygiene movement, and immediately found assistance in their efforts at induction centers to detect and bar the mentally ill from military service (Deutsch, 1944). In addition, both the army and the air force utilized the preventative and psychiatric corrective counsel offered at training

centers by implementing mental hygiene lectures given to incoming soldiers on army routine, as previously discussed under WWII treatment modalities (Deutsch).

The National Committee for Mental Hygiene became the National Mental Health Association in ~1950, and was reorganized in 2006 as Mental Health America. Over the years its mission has changed little with primary goals still being to increase public recognition and understanding of mental health issues, and to ensure that all Americans diagnosed with mental illness receive the best in care and treatment. With over 320 affiliates nation wide, Mental Health America still offers help to returning members of the military with programs such as Operation Healthy Reunions whereby information pertaining to a successful homecoming, coping with the aftermath of war, and coping with loss is disseminated.

The mental hygiene movement had done much to educate civilians and professionals about mental illness, but one of the hurdles in the military's delayed response to receiving psychiatric aide during WWII was "the great gulf [s] and conflict [s] existing between the several schools of psychiatric theory" (Deutsch, 1944, p., 365). None such abyss was more apparent than that which lay between the practices of biological psychiatry and psychoanalysis. Even with shell shock having been ruled psychic in nature during WWI, several medical psychiatrists still adhered to a medical etiology and physical treatment of mental illness. For example, in the first three decades of the twentieth century the notion that *all* forms of mental illness were caused by focal infection (chronic, untreated infection in the organs), was very much in vogue in Britain and the U.S. (Scull, 1999).



The superintendent of the Trenton State Hospital in New Jersey writes that the most common cause of mental disease was:

The intra-cerebral , biochemical cellular disturbance arising from circulating toxins originating from chronic foci of infection...the more we study our cases, we are forced to conclude that distinct disease entities in the functional group...do not exist. The aetiological factors are the same...[in] the whole so-called functional group, such as manic-depressive insanity, dementia praecox, paranoid conditions, the psychoneuroses, etc.” (Scull, 1999, p. 80).

Treatment involved the surgical removal of the infected organs, with the gastrointestinal tract, teeth, tonsils, and prostate receiving the most attention (Malamud, 1944). The Trenton State Hospital continued to espouse this doctrine until the mid-1950's when the field of psychopharmacology was established (Scull).

Not only were conflicts *among* different schools of psychiatry a deterrent to military acceptance, arguments *within* such schools of thought were even more provoking. Freud's emphasis on sex with regards to unconscious motives eventually alienated classic psychoanalysis from other psychodynamic approaches. Carl Jung, Alfred Adler, Karen Horney, and Anna Freud all practiced the basic tenants of psychoanalysis in the first half of the twentieth century, but theoretical perspectives unique to their interpretations only added to the confusion. For example, while Freud believed the past was what influenced behavior and placed developmental emphasis on childhood, Jung believed that both the past and future influenced present behaviors, and placed developmental emphasis on middle age. In addition, Jung did not believe that

libinal energy was sexual in nature, instead stating it was a “creative life force that could be applied to the individual’s continuous psychological growth” (Hergenhahn, 2001, p. 488).

In the late 1930’s Jewish persecution in Germany forced a mass emigration of leading German psychoanalysts to the U.S. They established several training institutes in cities across America and in new schools of social work (Crammer, 1999). But when the U.S. went to war in 1941, neurologists and institutional psychiatrists still provided the majority of treatment, with analysts making up a very small percentage of the psychiatric profession (Crammer). When it became apparent that they were unable to cope with the large numbers of psychiatric casualties, analysts associated with the field of medicine were signed up to assist in the assessment and treatment of soldiers experiencing combat-related trauma (Crammer). These analysts were responsible for the use of abreaction, as previously discussed under WWII treatment modalities, which was applied to a certain degree throughout the war. Whenever possible, additional psychoanalytic techniques were practiced, but the model of unconscious drives was not so easily adaptable in the war zone (Jones, 2000).

While abreaction was utilized, it is interesting to note that in very few cases did it operate without the physical treatment of insulin, ether, sodium-amytal, or sodium pentothal (Cardena et al., 2000). This combination of psycho-somatic intervention in WWII was also witnessed when soldiers were given large doses of barbiturates to initiate bed rest in combat fatigue cases, followed by the use of psychologically manipulative techniques that would get them back to the front lines as quickly as possible. The

working combination of both biological and psychodynamic models during WWII created a military psychiatry more purposeful in nature than their custodial counterparts who were catering to civilian neuroses in American mental institutions back home.

By the mid-1940's, when service men returned home, the mental health field was experiencing several changes which would impact their post war treatment. The National Mental Health Act was passed by Congress in 1946, creating the National Institute of Mental Health (NIMH), allocating millions of dollars for psychiatric research, the training of mental health personnel, and grants to help in the establishment of mental health clinics (Crammer, 1999). Unfortunately none of this federal funding went towards State mental hospitals but instead supported agencies, clinics, etc. which emphasized mental health as a part of biomedical science, and research which focused on preventative measures (Crammer). In keeping with this trend, the discovery during the war that peptic ulcers had a psychological etiology encouraged the development of psycho-somatic medicine and by the mid-1940's several specialty clinics were operating in general hospitals for the study and treatment of psycho-neuroses, mild psychoses, and "organ neuroses" (i.e., hypertension, skin diseases, gastrointestinal disturbances, allergies, etc.) (Malamud, 1944, p. 317).

Many physicians returning from the war were interested in furthering their psychiatric training after having witnessed acute combat-related trauma and successful treatment modalities. The following case illustrates a successful psychoanalytic outcome with the use of sedation:

A twenty-year old marine was admitted to the hospital approximately a week after evacuation from Guadalcanal. He appeared depressed and stunned; started sharply at any sudden sound; and could not halt his preoccupation with recent events. He ate poorly and his sleep was broken by nightmares. With considerable emotion he told of how his gun emplacement had been struck by a bomb. He had seen the remainder of the crew killed as he was tossed through the air by the concussion. He remembered nothing that happened for several hours thereafter, but did not think that he had been unconscious as he had been told that he had “gone wild” almost immediately.

In the hospital he could not control his sobbing during air raids and remained extremely jittery. While convalescing he suddenly became rigid and cataleptic. With suggestion, he took oral sedation, sobbed uncontrollably and finally began to talk. The story of the bomb-hit was retold. He had been sitting in the emplacement with his life-long “buddy” with whom he had gone to school, college and into the marines. His “buddy” had yelled, “Look out!” In the next moment he had seen his friend blown to bits. The episode had not been forgotten, but he had avoided mention of the friend as being too painful for discussion. Sharing his troubles, the patient began to improve...

(Lidz, 1946, p. 202 )

Such favorable exposure to psychoanalytically trained psychiatrists during the war changed prior negative views of the profession, and many physicians utilized funding

from the NIMH to further their training in the field (Jones, 2000). Because psychiatrists were thought to be in short supply, the GI Bill of Rights had also approved medical and analytic training for returning veterans, and by 1951 a total of 1,800 residencies had opened up across the country, up from 400 placements before the war (Crammer, 1999; Jones, 2000). After training, however, many psychiatrists settled into private practice or held positions with prestigious university training hospitals, with few electing to practice in hospitals run by the state (Crammer, 1999).

Returning soldiers with psychiatric symptoms initially overwhelmed civilian psychiatric hospitals which were limited in their ability to care for veterans (Jones, 2000). Many state hospitals were under-funded, over crowded, and more often than not contained terrible sanitary conditions which led to increased rates of tuberculosis, malnutrition, and other forms of infection among patients (Crammer, 1999). Some institutions had more than 10,000 inpatients with “as little as one doctor per 500 patients and one attendant per 15 patients, to cover the 24 hours” (Crammer, p. 134). The role of the institutional psychiatrist was primarily physical medicine (i.e., shock therapy treatments) and managerial in nature (Crammer), neither of which was helpful treatment for returning soldiers suffering from combat-related trauma. The VA’s establishment in 1930 had helped provide many veterans with mental health services, including assistance with reintegration concerns, but the system had many problems and suffered a series of scandals during the first few years (Baxter & Hathcox, 1994). Only after General Omar Bradley was appointed by President Truman in 1946 was the medical program

overhauled, and by the 1950's the VA became one of the leading forces in hospital care (Baxter & Hathcox.).

When the war ended service members returned home and were embraced as heroes and heroines by society-at-large. Entrance to the war had been preceded by enemy attacks, and the devastation of Pearl Harbor had unified the country in their backing of the war declaration. Public sympathy for soldiers suffering from war-related trauma had continued to evolve from WWI, and a greater acceptance of psychological treatment appeared to be present (Jones & Wessely, 2005). On the home front scarcity and sacrifice had been the theme, and Americans had banded together in the rationing of food, coal and gasoline, in order to support the war effort. News clips from October of 1942 state: "Citizens hold scrap metal, rubber and cooking fat drives, and invest billions in war bonds... Victory Gardens are continually springing up in backyards and vacant lots... Last year, 40 percent of all vegetables in the nation came from 20 million gardens" (20th Century Day By Day, 2000, p. 542). By the time servicemen and women returned from their respective war duties Americans were ready to leave the war years behind and celebrate the "spoils of victory" in which all citizens had played a role.

A reflection of the desire to move forward can be found in statistics relating to the number of children born in the U.S. post-war. Reaching levels not seen since 1910, the birth rate rose by two-thirds in the 1950's from the pre-war 1930's ("Population," 2007). Allied forces that had experienced great devastation during the war turned to America for goods and services as American natural resources had been left largely untouched. In support of their troops Americans had purchased millions of dollars worth of war bonds

throughout WWII and they proceeded to spend their savings on the magnificent variety of consumer goods available. Contributing to this vigorous economic growth were the record numbers of servicemen utilizing the GI Bill to attend both private and public universities. By 1955, 7.8 million veterans had taken advantage of the Bill, with a further 10 million veterans utilizing readjustment subsidies and vocational training (Jansson, 2005).

### *The Korean War*

In the aftermath of WWII social reform took a back seat to social spending, and many of the reforms initiated as a result of the Great Depression (i.e., the Civilian Conservation Corps, the Public Works Administration; the National Youth Administration; the Works Progress Administration) fell to the wayside in the 1940's (Jansson, 2005). With low unemployment and a booming economy, government became ambivalent to supporting social causes from a national perspective and Americans did not push for reform as they were experiencing the first period of affluence known since the years of the Great Depression. Several minority groups were nonetheless experiencing oppression, including women who were still restricted in their ability to own property, participate in legal contracts, and work in areas otherwise deemed masculine in nature – e.g., medicine, law, and business (Jansson). The granddaughters of suffragettes had been raised to believe that they were just as capable as their male counterparts to hold down jobs, raise a family, and participate fully in the social, political, and economic ideas of the day, but this liberalism was mocked by a society which believed a woman's place was in the home despite their numerable contributions during WWII.

The rise of television during the late 1940's and 1950's also played a significant role in the depiction of women primarily as housewives who naturally placed their family's interests before their own. In *The Adventures of Ozzie and Harriet*, the Nelson's were portrayed as the perfect all-American middle-class family with Harriet representing the picture-perfect housewife. In *I Love Lucy* Americans fell in love with the scatterbrained, well-meaning Lucy Ricardo who hungered for a job in show business but was refused entry by her husband. Finally, in *Leave It to Beaver* viewers watched as June Cleaver busied herself with social clubs, religious groups and the raising of her sons, while Ward Cleaver drove off to work every morning. The utter popularity of these productions was tremendous with both *Ozzie and Harriet* and *I Love Lucy* running for more than 10 consecutive seasons throughout the 1950's and into the early 1960's.

Other minority groups also experienced subjugation. American Indians dependent on government rations initiated during the Great Depression found themselves at the mercy of government politicians bent on decreasing national responsibility and acknowledgment of their plight. Asian Americans disenfranchised before WWII fought to overturn many of the racist policies, and were successful on many accounts, but immigration limitations on Asians continued well into the 1960's. Gay men and lesbians also suffered great prejudices and hostility after the war. Considered a mental illness, homosexuality led in many cases to involuntary commitment to mental institutions (Jansson, 2005). Witch-hunts to remove homosexuals from government positions due to "loyalty risks" resulted in the screening and consequential firing of thousands of individuals based upon their sexual orientation (Jansson, p. 259). African Americans also



faced great prejudices and horrific instances of racial discrimination as they fought for recognition and equality.

African American migration from the south, which began in WWI, became much more forceful in nature throughout the 1940's and 1950's. No longer needed on cotton farms due to improvements in technology, and weary of oppression and unemployment, a massive migration from southern rural farms to northern urban areas took place. Lacking in education and struggling to find jobs, many African Americans found themselves segregated in "densely populated urban ghettos, denied housing in white areas, limited to unskilled jobs, denied membership in unions, placed within segregated and inferior school systems, disenfranchised, and subjected to police brutality" (Jansson, 2005, p. 233).

Efforts by reformers in the lead up to the Korean War to garner federal funding for those in need were met with disregard (Jansson, 2005). Instead, international developments including Russia's domination over Poland, Czechoslovakia, East Germany, and other Eastern European countries led to the development of the Marshall Plan and ensuing fears among Americans of totalitarian regimes and the threat of communism. Truman's Doctrine speech in 1947 encouraged Americans to symbolically perceive the conflict as a struggle between democratic freedom and the evils of communism, embellishing the threat and "stirring the pot" in order to get Americans on board his foreign policy approach ("United States," 2007).

Determined to stop Russia from acquiring further geographical dominance, President Truman's economic assistance to Western Europe quickly became the primary

focus of treasury funds, and with the outbreak of the Cold War in 1950 military spending increased from approximately \$10 billion to \$40 billion annually (Jansson, 2005). When North Korea suddenly attacked South Korea in 1950, the U.S. Congress overwhelmingly approved Truman's decision to send troops to Korea, and approximately 75 percent of Americans concurred (Roberts, 2000). The victory of WWII still fresh in American minds, combined with fears of the possible negative domestic and international impact of communism, created overwhelming popular support among Americans.

Unfortunately, this support was not to be sustainable. After having conquered their enemies and demanding unconditional surrender with the drop of the atom bomb in WWII, Americans were no longer content to wage war at the cost of their social and economic freedom. Unpopular economic controls had been quickly implemented by the government, and rising inflation and taxes were already taking their toll. When it appeared that the hostilities were not going to be resolved with expedience, the American public quickly lost their enthusiasm for the war and the Truman administration which had fired their favorite general – Douglas MacArthur – at the very height of the conflict (Roberts, 2000). General MacArthur contended that a more “forceful prosecution of the war would have brought victory in short order” and Senator Joseph R. McCarthy agreed, stating that “such deficiencies were primarily a result of communist penetration of U.S. officialdom” (Roberts, p. 41). When it came time for Americans to elect a new president in the fall of 1952, they chose to support Dwight D. Eisenhower, the conservative ex WWII Army General who promised to bring a quick end to the conflict.

With the signing of the Armistice in 1953, the Korean War quickly came to an end, but “McCarthyism” was in full swing, creating great fear among many politicians, academics, attorneys, and individuals within business organizations, membership organizations, and the Hollywood film industry of being labeled as subversive (Time, 1951). It was estimated that one in every five employees underwent loyalty reviews throughout the late 1940’s and early 1950’s established within the private sector as well as several state-run offices (Brown, 1958). Even the military felt the brunt of McCarthy’s vengeance. In a 36-day nation-wide television broadcast, American’s watched as McCarthy accused the U.S. Army of concealing a spy ring among army officers and civilian officials, and questioned the practice of promoting servicemen who had refused to answer certain questions in their loyalty reviews (“McCarthy,” 2007). Including gay men in their hunt for communist sympathizers, more than 2000 people were removed annually from the military in the early 1950’s, a figure which rose to 3000 per year by the early 1960’s (Jansson, 2005).

An article in the 1951 edition of Time magazine entitled *The Silent Generation* depicts the ideas and spirit of youth during the era:

Youth today is waiting for the hand of fate to fall on its shoulders, meanwhile working fairly hard and saying almost nothing. The most startling fact about the younger generation is its silence. With some rare exceptions, youth is nowhere near the rostrum. By comparison with the Flaming Youth of their fathers and mothers, today’s younger generation is a still, small flame. It does not issue

manifestoes, make speeches or carry posters. It has been called the “Silent Generation.” (p. 45)

The correspondent goes on to suggest that this phenomenon was a result of fear of the draft, uncertainty of the atomic age, and fear of being singled out as seditious; all of which, the writer contended, had played a role in creating a generation more intent on conformity than applause.

This conformism was also felt in the field of mental health. Dr. Glen Gabbard, Bessie Walker Callaway Distinguished Professor of Psychoanalysis and Education, states in *The Evolving Role of the Psychiatrist from the Perspective of Psychotherapy* that while psychotherapy was still very much at the forefront of psychiatry in the 1950's, the field of psychiatry had taken the lead in neuroscience and psychopharmacology developments and was working to realign the specialty with mainstream medicine (2000). Recent Swedish identification of the neurotransmitter dopamine helped to produce the first maps of monoamine neurotransmitter pathways in the brain (Healy, 1999). In addition, tremendous growth was occurring in the development of neuroleptics in the treatment of schizophrenia, and for the first time science determined that a chemical agent could modify mental activity disturbed by psychotic processes (Olie & Loo, 1999). Discovering a drug which had the ability to control the symptoms and signs of psychosis was a major medical advance, and it was quickly followed by the discovery of antidepressants and tranquilizers. Benzodiazepines also made their first appearance during this timeframe, including chlordiazepoxide which was first synthesized in 1955, followed quickly by diazepam (e.g. valium)(Olie & Loo).

Gabbard states that the shift towards empiricism throughout the 1950's was largely due to accurate concerns that psychiatry was not being taken seriously due to "years of emphasis on psychoanalytic psychotherapy" (2000, p. 105). Scientific focus on psychopharmacology and neuroscience allowed psychiatrists opportunity to "remedicalize" within the field of medicine and show how valuable their contributions could be to the overall health and well-being of patients (Gabbard). Interestingly enough, this scientific focus also allowed behavioral therapy opportunity to garner a foothold within the field of mental health, much to the chagrin of classic psychiatry.

As Dr. Jerome Frank (2000) states in *Postwar Psychiatry: Personal Observations*: "...research findings and therapeutic results appeal to Americans. They are described in objective scientific jargon, and science enjoys a high prestige in American culture" (p. 195). Psychoanalysis, despite popularity, had been dismissed by the field of medicine as unscientific and criticized as being immune to falsification. In 1952, Professor of Psychology at London University, Hans Eysenck, studied the efficacy of treatment outcomes pertaining to psychoanalysis, and implied that treatment outcome "approximated to the spontaneous remission rate for neurotic disorders" (O'Dwyer, 1999, p. 173). Eysenck's work created great controversy in the field of mental health, but it assisted in opening the door to research on the psychological treatment of mental disorders and other psychotherapeutic techniques, including behaviorism.

While front-line psychiatric treatments did not differ significantly from WWII to Korea, much had been learned from the psychiatric casualties treated on the home front after WWII. The sheer numbers of soldiers suffering from combat-related trauma,

combined with the lack of qualified therapists to treat them, necessitated briefer, more effective psychotherapies that were less costly, less time consuming, and which had the ability to reach more soldiers (Frank, 2000). Such conditions created a much higher demand for psychiatric social workers and clinical psychologists, and slowly the development of time limited dynamic psychotherapies as well as cognitive-behavioral and group therapies began. These trends continued to be supported and hastened by advancements in psychopharmacology and neuroscience, where the attentions of psychiatrists were primarily focused (Frank).

For returning veterans of the Korean War, homecoming was a different experience from that of soldiers coming back from WWII. No clear victory had been won, and while the war had reached a cease-fire, no peace treaty had been signed (Edwards, 2006). Whereas WWII veterans had returned en-masse to victory parades and celebrations throughout the nation, because of a rotational point system which determined eligibility for homecoming, Korean War veterans arrived on U.S. soil individually without a lot of fanfare. Much had changed in their absence. Truman was no longer president, Joseph Stalin was dead, and Jonas Salk had discovered the first polio vaccine. Big bands were starting to be replaced by rock and roll, television programs were being broadcast in color, and Ian Fleming had published his first Bond novel, *Casino Royale* (Edwards).

The successor of the GI Bill, *The Veteran's Adjustment Act of 1952*, allotted up to 36 months of schooling along with an educational benefit of up to \$110 per month out of which books, supplies, and tuition were paid by the veteran (Edwards). The biggest

change between the original GI Bill and its successor was that tuition was no longer paid directly to the chosen institution of higher education, but by January 31<sup>st</sup>, 1965, more than 2.3 million Korean War veterans had benefited from the bill, only 7 percent fewer than returning veterans of WWII, with a total cost of the program at 4.5 billion (Edwards).

### *The Men and Women who Served*

At times, while reading historical accounts about war, it is easy to forget the names and faces of those who suffered under the auspices of democracy. The purpose of this section is to bring home the nature of the individuals who put themselves at great risk for their country, and to provide the reader with a humanistic perspective of those who served. Some limitations must be noted. Demographic material providing information on the soldiers who served in WWI is scant and difficult to source. More accurate records were kept pertaining to demographics on WWII and Korean War soldiers, and much more has been written about the individual consequences of battle from the perspective of these generations. Unfortunately, documented minority cases of Shell Shock from WWI were elusive. All cases thus far have been about young, white males who served either in direct combat or in theatre. Generally, not enough has been written about the women and minorities who served during the First World War, but there are a handful of narratives of which a few will be included here.

On May 18<sup>th</sup>, 1917, President Woodrow Wilson signed the Selective Draft Act, requiring all men between the ages of 21 and 30 to register for potential service in the U.S. armed forces. By October of 1918 more than 14 million men had registered, 3

million had been drafted, and approximately 1 million had volunteered (20th Century Day By Day, 2000). While relatively little demographic data is known regarding the cultural, socio-economic make-up of these veterans, and fewer than 200 survive today, we know they originated from all over America – towns and villages throughout the country, as well as large urban cities (Office of Public Affairs, 2003). Many of these individuals were African American, and a handful were women.

Very little is known about the women and minority populations who stood side by side in defense of their country during the First World War. Servicewomen and minority servicemen's gains were not acquired without great sacrifice and struggle; their successes paved the way for the women's liberation and civil rights movements (Dalfiume, 1971; Gavin, 1997). Initially, black Americans were assigned to play minimal roles in non-combat Services of Supply (SOS) units. Their responsibilities were to load and unload cargo, transport materials, lay railroad tracks, construct roads and camps, dig graves and ditches, and serve as military train porters and motorcycle couriers (Redstone Arsenal Historical Information (RAHI), 2007). While the French were impressed with their accomplishments, and awarded their bravery, the U.S. military did not fully appreciate their efforts, continuing ongoing segregation and discrimination practices which would not be completely abolished until well after the Korean War (RAHI, 2007).

The first women enlisted in the services were the Navy *yeomanettes* who worked as clerks, radio electricians, chemists, draftsmen, pharmacists, accountants, and telephone operators. A manpower shortage at Navy shore stations in 1917 had prompted the Secretary of the Navy to inquire as to whether or not a Navy *yeoman* had to be male.



Once it was discovered that no such prerequisite existed, he promptly placed a call for women to join the Navy and serve their country in time of need. Dubbed yeomanettes, (officially titled yeomen (F)), more than 11,000 served before the end of the war in 1918, providing a massive resource pool from which the Navy could draw (Gavin, 1997).

One of the first yeomen (F) to serve was Helen Dunbar McCrery of Seattle, WA. Lettie Gavin, author of *American Women in World War I: They Also Served* (1972), relays McCrery's story:

They needed girls who had stenographic skills; I was good at it. I could take dictation pretty fast. It was the Gregg method of shorthand, but I invented some of my own. They gave us uniforms just as fast as they could get them made. Oh, I had the neatest suit you ever saw. We had white shirts, and they were the devil because you always had a ring around the neck. We had to have two of them, because you had to wash one every night. (p. 2)

Unlike their male counterparts the yeomen (F) received no formal recruit training before starting their duties, but they took classes at night to learn Navy terminology and routines, and many of them included military drill training in their efforts (Gavin, 1997). The majority of yeomen (F) remained in the U.S., as they were not permitted to serve at sea, but as U.S. participation in the war increased several served in foreign countries in a variety of different capacities.

While yeomen (F) enjoy the notoriety of being the first females to join the military, their work was often long and arduous, and not without tragedy. The Spanish influenza epidemic in 1918 killed 548,000 U.S. citizens, almost twice the number of

combat soldiers killed overseas, and yeomen (F) often served as volunteers in the facilities where afflicted military and civilians were treated (Gavin, 1997). Many of the yeomen (F) lost friends, family members, and soldiers they were helping throughout the epidemic, and although there exists no formal roster detailing yeomen (F) WWI fatalities, it is known that fifty-one died while on active duty between 1917 and 1918 (Gavin). Yeomen (F) will always have a special place in military history as pioneers. For the first time women were paid equal wages to those of men in the same positions, and their dedication and commitment to their work opened several doors to women concerning a variety of occupations following the war (Gavin).

Taking their lead from the Navy, the U.S. Marines decided a year into the war that women might also be of assistance to them by freeing up deskbound men for active field services so they started recruitment procedures using the slogan “Free a Man to Fight” (Gavin, 1997, p. 26). Women were already serving overseas with the YMCA, the Salvation Army, the Army Medical Department, the Army Signal Corps, the French Army, and the International Red Cross. In 1917 the Red Cross had been asked to organize fifty base hospital units in Scotland, Ireland, England and France which later served as Army and Navy hospitals (Gavin). Thousands of women chose to go overseas with the Red Cross to help in nursing, the motor corps, canteen and communication services, and many helped build hospitals, and clinics for children, on allied ground (Gavin). And while American female physicians were not utilized by the U.S. military during WWI, they practiced in American Women Hospital dispensaries in several European countries which were funded by the Red Cross.

As American women tackled military inequity from many different angles, African Americans also stepped forward to volunteer, long before the draft, with the hope that their military contributions would end rigid discrimination and encourage democratic stability on the home front (Dalfiume, 1971; RAHI, 2007). Within the introduction of this thesis, attention was drawn to the extraordinary heroism garnered by the African American soldiers in the 371<sup>st</sup> and 372<sup>nd</sup> Infantry Divisions during the First World War, who were honored by France and received the Médaille Militaire and the Croix de Guerre; both highly coveted commendations (The Union, 1919). While the French openly acknowledged their bravery, it is interesting to note that despite several exceptionally heroic deeds by African American soldiers during WWI, it took the U.S. military over 70 years to award their valor and self-sacrifice with the prestigious Medal of Honor (RAHI).

Almost 400,000 African Americans served during WWI; 140,000 served in France alone, but only 40,000 participated in combat due to prejudicial military restrictions (RAHI, 2007). Despite their service racial tension in the U.S. increased, with race riots breaking out in Kansas, Nebraska, Illinois, Texas, Washington D.C., and other parts of the U.S. As the military became less trustful of recruiting African Americans, black soldiers themselves began to understand that, despite their service, upon discharge they were not going to be able to claim the rights of being a full-fledged American (Dalfiume, 1971). In spite of their allegiance blacks had continued to experience rejection from participation in the Red Cross blood program; they had no representation on national draft boards; and the policy of assigning black school children with special

textbooks where references to voting, elections, and democracy were excluded was still in effect (Dalfiume, 1971).

By the end of the First World War more than 30,000 women had served in the U.S. military, the YMCA, the Red Cross and the Salvation Army (Gavin, 1997). And by the time the Armistice was signed on November 11, 1918, approximately 1,400 blacks had served as commissioned officers (RAHI, 2007). Having experienced horrible segregation and discrimination during the war, it would have been natural for blacks, and other minorities, to have turned away when the call came in 1941 to serve. But instead of ignoring the plea for new recruits, the Second World War gave African Americans the perfect occasion in which to stir the conscience of white society. As the Pittsburgh Courier proclaimed in the early years of the war: “What an opportunity the crisis has been...for one to persuade, embarrass, compel, and shame our government and our nation...into a more enlightened attitude toward a tenth of its people!” (Dalfiume, 1971, p.146).

Despite severe enlistment restrictions placed on African American's by the Armed Forces, by the end of 1945 a total of 1,056,841 blacks had been inducted through the Selective Service (USGPO, 1948). Constituting approximately eleven percent of all registrants liable for service, blacks served in the Army, Navy, Marine Corps, the Coast Guard and the Air Corps. They operated in segregated units, were restricted to specific branches of the military, and had been unable to command even the lowest ranking white soldiers upon graduation from officer training facilities (Dalfiume, 1971; RAHI, 2000).

An African American Pearl Harbor survivor, who served officers in the Navy, wrote the following sonnet in response to prejudices he encountered during his service:

I've traveled far, and I have traveled wide.  
It seems no matter where perchance I roam,  
The hated arrow heads that pierce my side,  
Were shot there overseas and here at home.  
Some years ago, I joined the Navy true.  
A proud black sailor man I cared to be.  
I beamed with pleasure in my suit of blue,  
Until officers' N-words did curse me.  
Next, while ashore in a land far away,  
This sailor man a pretty girl did greet.  
She said, "Dark Yanks have tails," white sailors say.  
"You, monkey boy, I do not care to meet!"  
Ofttimes, I wonder why God made me black,  
And put vast worldwide burdens on my back.

(Liston, 2003, p. 100)

African Americans showed great courage and vitality in WWII, none greater than that depicted by the Tuskegee Airmen who flew with distinction against the Luftwaffe who nicknamed them "Schwarze Vogelmenschen" – the Black Birdmen. But despite their valor, once again it took the U.S. military decades to honor their service. Only in 2007 did President George W. Bush award them with the Congressional Medal of Honor in

recognition of their deeds. Other minority groups also served at their best, and thousands registered with the Selective Service including over 10,000 American Chinese; 20,000 American Japanese; almost 20,000 American Indians; more than 10,000 American Filipinos; over 50,000 Puerto Ricans; and just over 1,000 Hawaiians (USGPO, 1948) Women also enlisted.

Once again women stepped up to the plate to join the armed forces in the wake of Pearl Harbor, and thousands served as WAVES (Women Accepted for Voluntary Service, Navy), SPARS (Women's Reserve of the Coast Guard), WAAC's (Women's Army Auxiliary Corps), WASP's (Women's Airforce Service Pilots) and USMCWR's (U.S. Marine Corps Women's Reserve). In total, over 350,000 American women volunteered to serve in the armed forces during WWII of which more than 59,000 were registered nurses with U.S. Army Nurse Corps (Monahan & Neidel-Greenlee, 2003). Of the nurses, thousands served in frontline hospitals located in combat zones; sixteen were killed by enemy actions; over seventy were held as POW's by the Japanese for over three years; and approximately 1,600 received various accommodations including the Distinguished Service Medal, the Legion of Merit, the Silver Star, the Bronze Star, and the Purple Heart (Monahan & Neidel-Greenlee). Many nurses worked closely with soldiers suffering from combat-trauma, and many witnessed the breakdown of hospital staff that also fell victim to the daily stress of performing under combat conditions. Monahan & Neidel-Greenlee, in their book entitled *And if I Perish: Frontline Army Nurses in World War II* (2003), write an account of one such nurse:

Lieutenant Miernicke remembered witnessing the mental breakdown of one doctor. It occurred during one of the daily, near-routine German shelling; shells had been falling near the hospital for about thirty minutes and were still landing every minute or so around the site. Miernicke, on duty in the OR tent, left to go to the adjacent supply tent for an item that was needed immediately. “As I walked into the supply tent,” she recalled, “I saw one of the hospital’s surgeons cowering in a corner of the tent. He was sitting on the floor in a modified fetal position and he was dressed in a surgical gown and gloves. He was seated on a metal bedpan and had placed a bedpan on his head. He was hugging his shoulders and had a bedpan over each elbow. His eyes were wide open and staring into space. I was so shocked and so moved by his condition that I didn’t say a word.” (p. 298)

During WWII Army and Navy nurses were granted full military rank, but this had been on a temporary basis, so after the war both military branches introduced legislation to establish a permanent place for servicewomen under the Women’s Armed Services Integration Act of 1947 (Witt, Bellafaire, Granrud, & Binker, 2005). While women and their supporters were calling for action on this legislation, African American leaders, including A. Philip Randolph, were pressuring President Truman to sign Executive Order 9981, which would establish equality of treatment and opportunity in the armed services for individuals of all races, religions, or national origins (“Randolph,” 2007; “Truman,” 2007). By the time America became embroiled in the Korean War both legislations had been approved, but many restrictions which would restrict enlistment and service had been integrated into the overall legal verbiage. For example, the highest rank

a woman could attain was colonel, or, if she was serving in the Navy, captain (Witt et al.). Women were also prohibited from serving on combat ships or aircraft, and their numbers could not exceed more than 2 percent of the regular parent (i.e., Army, Navy, etc.) service (Witt et al., 2005). Meanwhile, Executive Order 9981 took several years to implement, with the U.S. Army initially refusing to go beyond the 10 percent quota that was designed to protect individual units from being flooded with African American troops (Boose, 2000). When the first ground forces entered Korea in the summer of 1950, black and white soldiers were still fighting in separate units (Boose; RAHI, 2007).

On September 30<sup>th</sup>, 1954, the Secretary of Defense announced that the last all-black unit had finally been abolished, but it was not until the Vietnam War that Executive Order 9981 was fully realized. Nevertheless, the Army announced that by early 1951 almost 10 percent of blacks in theatre were serving in integrated units, and by April, for the first time in history, blacks in Korea were serving in combat positions at about the same percentage (41) as whites (Edwards, 2006). By 1952 the Air Force had only one segregated unit in operation, and blacks made up more than 5 percent of the enlisted men in the Marines (Edwards).

During the Korean conflict women performed a wide array of jobs in personnel and administration, food service units, communication, intelligence, and supply, with over one-third serving as health professionals (Edwards, 2006). While the Department of Defense tried to recruit women by glamorizing newspaper stories and media events, by 1951 women still made up less than 1 percent of personnel in each service (Edwards;



Witt et al, 2005). In their book *A Defense Weapon Known to be of Value: Servicewomen of the Korean War Era*, Witt et al. write:

The majority of the target group, young American women, treated military service in much the same way they treated civilian jobs they gravitated to in the early 1950's: temporary stops along the road to marriage and motherhood, which seemed inevitabilities given the messages society was sending them. (p. 7)

For the men who served on the frontlines during the Korean War, many can still call to mind the environmental extremes associated with combat with great clarity.

Korean War veteran, Paul Edwards (2006), writes about how exhausted the men were and how conditions extorted an enormous levy on the men:

In the summer, the heat and humidity turned any movement into a sweat bath with no place to cool off...In addition, the monsoon came like torrents, making the roads into bottomless pits of mud and slush. The trenches where the men waited were full of dirty water, sometimes up to their waist, resulting in crud and fungus in the summer, frostbite in the winter. (p. 88-89)

Frostbite was a serious concern as it would develop quickly as perspiration froze, and soldiers had to change their socks at least once a day so as to keep it at bay. Edwards recalls that in the winter months soldiers were underdressed, undersupplied, and so cold that stimulants had to be applied in many cases to revive depressed respiration. He continues:

When it was really cold, equipment did not work. Men became incoherent. Even the gases used to propel the bullet from the chamber of the M-1 [were] so

weakened that it was hardly strong enough to drive the projectile... C rations froze in the cans...food had to be warmed in the mouth before it could be chewed... blood froze and plasma became useless; morphine had to be kept warm to be of any use. (p. 92)

Edward's reflections are not unlike the remembrances of other soldiers who have served on the frontlines, but hardships are endured by all who serve in time of warfare. Personal wants and needs are set aside in order to join together and fight for a common good. While military objective is often met creating cause for cease-fire, the aftermath of war plays havoc on social, economic, and political systems for years to come, and catharsis becomes an individual, as well as collective, process. War forces us to tear down childish ideologies and seduces us into believing that "our side" shall be the moral victor. War can also serve to advance the course of medicine, and mental health, as we have seen here, simply through the sheer numbers of individuals seeking treatment and healing. As we leave behind the spirit of the times as reflected in the first half of the twentieth century, and step into the zeitgeist surrounding the Vietnam War, once again we will examine how existing ideas influenced treatment, methods, explanations, and outcomes of combat-related trauma.

CHAPTER V  
THE VIETNAM WAR

*“Going to war is a landmark experience in the life of an individual, an episode of tremendous importance, but in the case of Vietnam vets, you learned quickly to repress it, keep it a secret, shut up about it, because people either considered you a sucker or some kind of psychopath who killed women and children”*

*Bobby Muller, Founder of Vietnam Veterans of America (Quoted in Scott, 1993, p. 95)*

The Vietnam War was unlike any conflict preceding it, or any battle which has since transpired. While some have said that “war is war,” and similarities can be found among those who command, defend, and endure, Vietnam turned America upside down politically, socially, and economically. Adverse and hostile American reactions to the ongoing international conflict, combined with racial tensions on the domestic front, created a decade filled with radicalism, change, accomplishment, and disaster. This international and domestic turmoil, combined with massive strides in science and technology, unprecedented prosperity, and leadership in the form of John F. Kennedy, Martin Luther King, Lyndon Johnson, and Richard Nixon, created a zeitgeist unlike any other in America’s history; rendering the decade deserving of individual attention. Eric F. Goldman, Princeton historian and special assistant to President Johnson in the late 1960’s, agreed, remarking “This period was a watershed as important as the American Revolution or the Civil War in causing changes in the United States” (Koerselman, 1987,

p. 6). In an attempt to review these changes and their possible impact on the diagnosis, treatment, and understanding of combat-related trauma, this chapter will highlight a handful of the contributing individuals and events. Reintegration, along with community expectations and perceptions of combat-related trauma, will also be explored and brief descriptions from those who served will be woven throughout.

When Americans elected John F. Kennedy as the 35<sup>th</sup> President of the United States in one of the closest races ever, they initiated a changing of the guard. Eisenhower and the conservative 1950's were left behind, replaced by the eloquent moral idealism of Kennedy. Young, vigorous, and well educated, Kennedy seemed to fascinate rich and poor, black and white, young and old, liberal and conservative. In his inauguration address, which took place on the fresh snow-covered steps of the Capital on Friday, January 20, 1961, Kennedy challenged his fellow citizens:

Let the word go forth from this time and place, to friend and foe alike, that the torch has been passed to a new generation of Americans – born in this century, tempered by war, disciplined by a hard and bitter peace, proud of our ancient heritage – and unwilling to witness or permit the slow undoing of those human rights to which this Nation has always been committed. (Bartleby, 1989)

Kennedy's inauguration was televised live and in color across the nation, and Americans were caught up in his youthful promises filled with moral certitude. The "new generation" of which he referred was young, vocal in their convictions, and seemed to have an insatiable appetite for everything "modern." Advertisements on sleek new billboards, television, and in glossy magazines, such as Vogue and Cosmopolitan,

featured glamorous clothes, fast cars, and the latest electronics. Tips on intimate entertaining, exposés of popular film stars and models, and books such as Helen Gurley Browns' *Sex and the Single Girl*, which encouraged women to pursue the single life along with a satisfying career and financial independence, were all the rage. But meaningful social dialogue was also prevalent. Films promoting sexual themes, including *Splendor in the Grass* and *John and Mary*, also covered matters which could occur in tandem with love-making such as guilt, jealousy, and misunderstandings (Koerselman, 1987). Other concerns of the day captured in Technicolor, which Americans discussed and intellectualized, included racial prejudice (i.e., *In the Heat of the Night*; *Guess Who's Coming to Dinner*; *To Kill a Mockingbird*), middle-class hypocrisy (i.e., *The Graduate*; *The Apartment*; *Who's Afraid of Virginia Woolfe?*), and changing American values and attitudes (i.e., *Easy Rider*) (Koerselman).

More leisure time for recreational activities, and the means by which to enjoy them, was due in part to a booming economy as well as significant technological advances. Sparse international competition allowed U.S. exports to continue dominating markets world-wide throughout the 1950's and 1960's (Jansson, 2005). Increased wages and circulating funds from social programs such as Social Security buoyed economic growth, as did the relationship between government and both the housing and automobile industries (Jansson). By providing low interest housing loans to veterans and other homeowners, and bankrolling the majority of the costs for a massive national expansion of America's highways, the government contributed to a soaring housing market in the suburbs and the ensuing demand for more automobiles (Jansson; Koerselman, 1987).

Also contributing to the economic surge was the federal release of funds for construction in impoverished neighborhoods; an increase in provisions for farmers; reduced Small Business Administration loans; and an income tax reduction amounting to just under \$10 billion (Koerselman, 1987). Tax policies allowing Americans to deduct interest payments on home mortgages and loans also contributed to economic growth; albeit indirectly (Jansson, 2005). By 1963 the Kennedy administration had increased economic spending in several government sectors including the military, education, health care, space, urban renewal, and welfare assistance programs (Koerselman). Kennedy's initiatives kept inflation at 1.2 percent, decreased unemployment from eight to five percent, increased manufacturing capacity from 72 to 87 percent, and increased spending for capital improvement by 20 percent (Koerselman). America's economy was in high gear.

Science and technology were also experiencing great strides. Improvements in the production of cheap electricity enabled Americans to purchase household appliances such as dishwashers, self-cleaning ovens, and vacuum cleaners. Modern jet travel permitted the masses to visit far-away destinations previously reserved for the very wealthy. And Kennedy's \$5 billion federal outlay to the space program sent America's first astronaut Alan B. Shepard into space on May 5<sup>th</sup>, 1961; followed quickly by astronaut John Glenn's three orbits around the earth (Koerselman, 1987). Glenn became a superhero overnight and his accomplishment affirmed American idealism and confidence in their "individualism, organizational genius, scientific and technological superiority, pioneering

spirit, and above all, the pre-eminence of democratic capitalism and a free society” (Koerselman, p. 42).

Scientific advances were also occurring in the fields of medicine and mental health. Dr. Michael De Bakey from the U.S. and Dr. Christiaan Barnard from South Africa were both instrumental in the development of life-saving cardiac procedures during this timeframe. De Bakey implanted the first artificial heart in the chest of a 65 year old Illinois coal miner, and Dr. Barnard performed the first heart transplant on a patient who lived for 18 days before dying of double pneumonia (Koerselman, 1987; “Barnard, Christiaan,” 2007). Major advances in allo-plastics created brain-drainage tubes used in brain surgery, as well as life-prolonging Starr-Edwards heart valves and silicone-covered pacemakers – the first of their kind (Koerselman, 1987).

Within mental health, two randomized clinical trials initiated in 1961 once again gave credence to the biological model of psychiatric illness. In the first study which was conducted using a double-blind methodology, ground breaking research on phenothiazines established the efficacy of drug therapy with schizophrenic patients (Grob, 1999). In the second study, utilizing randomization and control groups over a six year period, Benjamin Pasamanick and his associates showed significant results among patients in the application and administration of drugs in a home-care setting (Grob). Studies such as these challenged the legitimacy of psychodynamic and psychoanalytically trained psychiatrists as well as the necessity for the institutionalization of the chronically mentally ill. They also gave way to treatment approaches based on community intervention supported by the federal initiatives.

Additional changes in the field of mental health were also playing a role in the restructuring of psychiatric services. Since the inception of the NIMH (National Institute of Mental Health), focus had slowly shifted from improving facilities and treatment measures at mental health hospitals to outpatient and community preventative programs (Grob, 1999). Community psychiatry and private practice replaced employment in mental hospitals, leaving the chronically mentally ill in rapidly diminishing institutions which were, at best, simply custodial in nature and a place of last resort (Jones, 1999). Extremely influential in the 1960's, community psychiatrists were activists, closely linked to federally funded social programs involved in preventative services, who believed that mentally ill individuals needed to be treated within their own communities instead of being committed to institutions (Grob; Halleck, 2000). Confinement, they argued, was counter-productive and did not help to reintegrate the mentally ill into society (Grob). Preventative services in community psychiatry included promoting activities that might reduce psychiatric illness (i.e., improving prenatal care to reduce incidents of post-partum depression); early identification of psychiatric disorders; and reducing the rate of defective functioning caused by mental disorders (Bey, 2006, p. 140). Bottom line: community psychiatrists played an instrumental role in the deinstitutionalization of mental institutions in America, as did advances in psychoactive medications, concerns regarding the civil rights of patients committed, and the shift in financial support from state to federal coffers (Jones).

Unable to continue shouldering the burden of escalating operating costs in aging state institutions constructed in the middle of the 19<sup>th</sup> century, states turned to the federal



government for much needed assistance. Heeding the recommendations of community psychiatry, and apprehensive about the substantial costs associated with the rebuilding of state institutions around the country, the Kennedy administration implemented the Community Mental Health Centers Construction Act (CMHCCA), and federally funded Aid to the Disabled (ATD) (Jansson, 2005; Lamb, 2000). ATD provided financial aid for the mentally ill within their communities – just enough to allow them to support themselves or in facilities such as board-and-care homes (Lamb). CMHCCA initiated the construction of mental health centers around the country which were to focus on inpatient treatment, emergency services, partial hospitalization, outpatient treatment, and preventative services (i.e., education and consultation)(Jansson; Lamb).

Originally designed as a mental health safety net, community mental health centers were to serve all members of the community, including Medicaid recipients, regardless of their socio-economic standing and their ability to pay for services. Unfortunately, due to ongoing political disagreements, expectations that such centers would fill the void left by rapid deinstitutionalization, and diminished government funding, community mental health centers became busy attending to the needs of children and adults with severe mental illnesses that were life-threatening or required prolonged intervention, with little preventative focus (Hartley, Bird, Lambert, & Coffins, 2002; Jansson, 2005; Lamb; 2000).

While the Kennedy administration was intent on resolving domestic issues related to the war on poverty and equality among blacks and whites, problems with the pro-western Southern Vietnam regime of Ngo Dinh Diem was creating significant obstacles

on the international front. Financially and militarily fortified by the U.S. since the 1950's, Diem's government was experiencing a growing problem with communist infiltrators from the North and a growing insurgent population in the South (Koerselman, 1987). Refusing to assign further military resources to the region, in November of 1963 Kennedy fell victim to an assassins bullet only days after Diem's murder in a bloody military coup (Koerselman). While Americans mourned in disbelief over the loss of their "Camelot," South Vietnam's conflict with the North quickly became a leading concern on the agenda of incoming President Lyndon B. Johnson and domestic concerns, including the mental health transformation, briefly came to a standstill.

After two U.S. destroyers reported being attacked by Northern Vietnamese forces in early August of 1964, President Johnson promptly called upon the U.S. Senate to approve his Gulf of Tonkin Resolution; the comparable equivalent of a declaration of war without the legalities (Koerselman, 1987). Within a relatively short period of time, it became apparent to Johnson's administration that the North Vietnamese and the National Front for the Liberation of South Vietnam (NLF; i.e., Viet Cong) were committed to reuniting the South with the North, and their devastating attacks using guerrilla warfare tactics were crippling American assets and South Vietnamese airfields, cities and towns (Koerselman; "Vietnam War," 2007). In March of 1965, Johnson committed the first combat troops into Da Nang – 3,500 Marines (Koerselman). The Selective Service System had been quickly revitalized in order to conscript the young soldiers, but with very few federal guidelines on whom to draft and whom to exempt, the process became alarmingly discretionary in manner. By enrolling in higher education privileged men

were perceived as allowed to defer conscription while minorities and individuals from lower socio-economic classes were called upon to serve (“Vietnam War”). By the end of the year almost 200,000 American military personnel were in Vietnam, with another 500,000 committed over the following two years (Koerselman). The Draft Lottery, which commenced on December 1, 1969, expedited the conscription process. In total, over a ten year period, approximately 9,200,000 American service members would serve in the Vietnam War worldwide, with approximately 3,403,000 dispatched to Southeast Asia (Office of Public Affairs, 2003).

One serviceman who was deployed prior to the Lottery was a 19 year-old Puerto Rican combat medic named Gonzales (pseudonym) who had been in the field for seven months when he presented to Specialist Smith in Dau Tieng. His story of combat-related trauma is relayed by Douglas Bey in his book *Wizard 6: A Combat Psychiatrist in Vietnam* (2006):

During his initial interview...it became apparent that Gonzales had been experiencing increasing internal and external stress for some time. Two months prior to the referral he had been wounded during an ambush in which his commanding officer was killed and several close friends were killed or wounded. During the confusion following a retrograde movement (retreat), several wounded men were apparently left briefly in the field. The medic returned under fire to aid them but was unable to save the life of one who was his friend. He attempted to carry his seriously wounded CO, whom he later said he admired and respected like a father, to safety but was unable to do so because of his small stature and his

own wound. When ordered to the rear, he became hysterical and was evacuated by helicopter before some men whom he considered to be more seriously wounded and in greater need of surgical attention. (p. 151)

Gonzales received medical attention by a social worker/psychology technician who understood his culture and helped him mourn the loss of his friends. Specialist Smith also enabled Gonzales to take a realistic look at the scope of his responsibilities during the exchange in order to address his guilt at having survived the firefight while others died. Not all servicemen and women were as fortunate as Gonzales in receiving good mental health treatment when it was needed.

Psychiatrist Robert Lifton writes about veteran experiences with psychiatrists in Vietnam, in C.R. Figley's (Ed.) book *Stress Disorders among Vietnam Veterans: Theory, Research and Treatment* (1978):

The men spoke with the same bitterness about "shrinks" they had encountered in Vietnam. They described situations in which they or others experienced an overwhelming combination of psychological conflict and moral revulsion, difficult to distinguish in Vietnam. Whether one then got to see a chaplain, psychiatrist, or an enlisted-man-assistant of either, had to do with where they were at the time, who was available, and the attitudes of the soldier and the authorities in his unit toward religion and psychiatry. But should he succeed in seeing a psychiatrist he was likely to be "helped" to remain at duty and (in many cases) to carry on with the daily commission of war crimes, which was what the ordinary

G.I. was too often doing in Vietnam. Psychiatry for these men served to erode whatever capacity they retained for moral revulsion and animating guilt. (p. 219)

For the first time in history, via modern media sources transmitted from Vietnam, the war crimes referred to by Dr. Lifton's patients were witnessed by Americans watching the evening news and reading their morning newspapers. The mistaken desecration of the Vietnamese village of Deduc which resulted in 48 civilian deaths and 55 civilians wounded, along with additional accidental bombings, were evidence of a war out of control (Koerselman, 1987). Unlike journalists in prior wars who had concentrated on the positive in order to unite the country and prevent possible panic, those reporting from Vietnam were fast becoming disenchanted with the status quo.

Instead of devoting media time depicting American troops fighting off the "enemy" for the sake of democracy, U.S. newscasts focused on the emotional stories of those left behind, often featuring the poignant images of flag-draped coffins arriving from the war zone (Koerselman, 1987). As people began to view published photographs, news stories, and news reels of the human tragedies associated with the war, many began to question the conflict's legitimacy. A Gallup poll taken in 1967 showed that 41 percent of Americans believed that the decision to send ground troops to Vietnam had been a mistake; with only 23 percent of the population supporting President Johnson's handling of the war (Koerselman). Vietnam was polarizing Americans. While dissenting voices were loud and conspicuous, many supported the war, fearing that a "domino effect" would take place and communism would prevail if South Vietnam fell victim to her Northern enemy (Koerselman).

At home the media was also playing a role in the unfolding of the civil rights movement. Public opinion in favor of civil rights legislation was extremely strong in the 1960's, in part due to the negative publicity of the escalating violence against blacks in the south (Jansson, 2005; Koerselman, 1987). Resistance of southern politicians in following federal laws to register blacks to vote, and desegregate the mass transit system as well as southern schools and universities, infuriated northern whites who considered themselves democratic and egalitarian (Jansson). Whites had also become sympathetic and supportive of the head of the Southern Christian Leadership Conference, Dr. Martin Luther King, whom many found to be sincere in his non-violent and open approach to obtaining equality for blacks, and indeed, all individuals suffering from poverty and oppression (Jansson; Koerselman).

Having discovered the non-violent measures of Mahatma Gandhi during a speech given in 1950 by Dr. Mordecai Johnson, president of Howard University, King was instantly mesmerized with the profundity of Gandhi's message (King, 1998). Nine years later, after he had visited India and met with Gandhi's family, King returned to the U.S. certain that nonviolence was the means in which to achieve freedom and equality for all:

I left India more convinced than ever before that nonviolent resistance was the most potent weapon available to oppressed people in their struggle for freedom...The way of acquiescence leads to moral and spiritual suicide. The way of violence leads to bitterness in the survivors and brutality in the destroyers. But the way of nonviolence leads to redemption and the creation of the beloved community. (King, p. 134)

Through King's initiative the "sit-in" movement came to fruition, whereby southern blacks began to infiltrate segregated lunch counters in non-violent protests which quickly gained momentum despite police threats of tear gas, arrests, and jail sentences (King, 1998). Peaceful demonstrations in the nation's capital, along with direct action taking the form of "bus protests, economic boycotts and mass marches" beseeched white Americans to sit up and acknowledge the appalling circumstances of their black southern neighbors (King, p. 139). African American students were at the heart of the movement, expanding their campaign from city to city while demonstrating a "glowing example of disciplined, dignified nonviolent action against the system of segregation" (King, p. 137). As northern support for blacks developed and strengthened in the form of the Civil Rights Act's of 1964, 1965, and 1968, most Americans thought the crisis averted and turned their attentions once again back to issues surrounding the Vietnam War.

Black domestic unrest spilled over into the combat zone in Vietnam. Serious racial tension was noted by Army combat psychiatrist Douglas Bey, who served in Vietnam between 1969 and 1970. Bey (2006) writes that for black soldiers fighting in Vietnam, their disproportionate numbers compared to whites was seen as an example of white prejudice and a desire of the U.S. system to eradicate them. Bey reports that blacks comprised 10 percent of the military but approximately 20 percent of combat infantry units, and less than 3 percent of the officer corps. He also states that many of the black men serving in Vietnam were high school dropouts from run-down and densely populated neighborhoods. Conversely, Bey writes, "the officers were mostly white college-

educated, newly trained lieutenants who had little or no experience commanding troops or dealing with inner-city blacks” (p. 80). The officers responded to their fears and misunderstanding of black culture by prohibiting outward signs of black solidarity including certain forms of music, clothing, and power salutes, which only served to aggravate the situation. While research informs us that minority status alone is not a risk factor for the development of combat-related PTSD (Friedman et al., 2004; Penk et al., 1989; Trent et al., 2000) or the manifestation of symptoms (Frueh et al., 2004), there is evidence that military racism contributed to increased PTSD rates among African American soldiers who served in Vietnam (Allen, 1986).

By the mid-1960's American military spending, as well as interest on the national debt, comprised of almost 70 percent of the federal budget as compared to 28 percent devoted to domestic programs (Jansson, 2005). International support among her allies was growing thin, with angry protests and criticisms of American foreign policy frequently taking place on the floor of the United Nations (U.N.; Koerselman, 1987). Martin Luther King petitioned President Johnson, in addition to U.N. Ambassador Arthur Goldberg, to seek peace by negotiating directly with the National Front for the Liberation of South Vietnam (NLF), admitting China into the U.N., and ending the American bombing of North Vietnam (King, 1998). Initially King had refused to become politically involved with the ongoing crisis, but concerns that the war was taking precedence over domestic priorities forced him to become more vocal:

My direct personal experience with Negroes in all walks of life convinced me that there was deep and widespread disenchantment with the war in Vietnam – first,



because they were against war itself, and second, because they felt it has caused a significant and alarming diminishing of concern and attention to civil rights progress. (King, p. 336).

King was joined by other social, literary, political, and military giants in his anti-war campaign. G. H. Koerselman (1987), in his book *The Lost Decade: A Story of America in the 1960's*, quotes retired general James M. Gavin and popular vocalist Ertha Kitt on their stance. Also a noted military analyst, Gavin remarked "In Vietnam we have lost sight of our national objectives and let what started as a limited war expand in time, cost, and effort" (p. 179). Kitt declared to Ladybird Johnson during a White House luncheon for women "We sent the best of this country off to be shot and maimed...they don't want to go to school, because they are going to be snatched off from their mothers to be shot in Vietnam" (p. 179). Koerselman goes on to state that unfortunately for Ms. Kitt and others involved in the anti-war campaign, the majority of members in the U.S. government, reluctant to admit defeat, still supported the war effort as did many Americans. As draft boards continued to conscript young men in a random and questionable manner, youth disillusionment with the system began to materialize in the shape of war protests and experimentation with moral principles and unconventional forms of lifestyle (Koerselman; "Vietnam War," 2007).

On April 17<sup>th</sup>, 1965, fifteen thousand students, organized by the Students for a Democratic Society (SDS), marched peacefully in front of the White House demanding an immediate withdrawal of American troops from Vietnam while President Johnson was entrenched in his Texas ranch for the weekend (20<sup>th</sup> Century Day By Day, 2000, p. 933).

As time progressed and their voices were left unanswered, the rallies became less peaceful and more demonstrative with students burning their draft cards and seizing administration offices on college campuses. Accepting of President Kennedy's earlier vision of their responsibilities as the "new generation," and fortified by Robert Kennedy's statement "Not since the founding of the Republic has there been a generation of Americans brighter, better educated, more highly motivated than this one," students and youth alike joined together to voice their disapproval of the ongoing war in Vietnam (Koerselman, 1987, p. 186). Oblivious to the student unrest, in late July of the same year President Johnson doubled the number of young men to be drafted from 17,000 per month to 35,000, and made it illegal to burn draft cards (20<sup>th</sup> Century Day By Day, 2000, p. 936).

Opposition to the war, even in the early stages, created a rebellion against the military establishment referred to as *indiscipline* by military psychiatrists (Bey, 2006; Jones, 2000). Indiscipline referred to various military infractions which included everything from unavailability for combat to serious acts of disobedience (mutiny) and fragging (Jones). While many incidents of fragging have been recorded in association with the latter phases of the Vietnam War, passive aggressiveness was the norm and usually expressed through obstructionism, pouting, procrastination, intentional inefficiency, or stubbornness (Bey). Some soldiers, conscripted despite their anti-war protests, chose to wear black arm bands during their service in order to display their convictions.

Youth rebellion was not limited to the state of affairs in Vietnam. Fear of nuclear war; the divisive aspects of modern industrial life; the lack of diversity on college campuses; and a rejection of middle-class standards and moral values all provided momentum for a youthful population revolting against convention (Koerselman, 1987; Time Magazine, 1970). Tired of conformity, young men and women rejected the life of corporate America, finding it limited in imagination and abundant in hypocrisy. Basic western assumptions and values were questioned, and a liberalization began to take place that quickly spread from college campuses to the streets (Koerselman). Draft resistance increased and protestors became more militant in their efforts to stop American involvement in the war.

When Johnson announced at the 11<sup>th</sup> hour that America would try to negotiate peace with North Vietnam using diplomatic methods, it was already too late for his presidency. Tired of seeing the thousands of dead and wounded American soldiers returning from the war; disappointment in Johnson's inability to end the conflict quickly as per the promises of his 1964 campaign; fear of increasingly militant protests assisted by the assassinations of Martin Luther King and Robert Kennedy; and steadily rising inflation due to the war's enormous financial cost, all played a role in America's distrust of the administration, and Johnson's decision to forgo a second term (Koerselman, 1987; Jansson, 2005). Pledging to restore law and order at home and "end the war and win the peace" with honor in South East Asia, Richard Nixon became the 37<sup>th</sup> President of the United States (Koerselman, p. 239).

Intent on stopping the war as quickly and diplomatically as possible, and saving the U.S. from an overextended financial situation, in November of 1969 Nixon's government initiated a new foreign policy which stipulated that the U.S. would honor current treaty commitments and supply military and economic assistance in cases of other aggression, but only after the threatened nation assumed principal responsibility for its security ("International Relations;" 2007). Referred to as the Nixon Doctrine, the guidelines were quickly applied to various international locales including the Middle East in response to military aid provided to Iran and Saudi Arabia - setting the stage for a future role in Kuwait and Iraq (Beinhart, 2007). In conjunction with the Nixon Doctrine, peace talks were held with both China and the Soviet Union to ease international tensions and domestic unrest ("International Relations"). Unfortunately, as Nixon and his administration were working behind the scenes to secure peace, several events recorded by the media kicked up massive war protests once again.

In the fall of 1969, a soldier-photographer who had accompanied C Company, of the 1<sup>st</sup> Battalion, 20<sup>th</sup> Infantry, Americal (23<sup>rd</sup> Infantry) Division, sold photographs to the Associated Press depicting an event which was quickly dubbed the "My Lai Massacre" (Scott, 1993). Eighteen months earlier C Company had entered the subhamlet of My Lai for a search and destroy mission, mistakenly expecting heavy resistance from NLF forces, and proceeding to kill more than four hundred women, children, and elderly men (Scott). Charlie Company had experienced many casualties in this area previously and suspected villagers of harboring Viet Cong. Military sources had been able to hush up the massacre for some time, but once photographs featuring the dead civilians hit the

newsstands, along with accounts that the massacre was intentional, American resistance to the war increased significantly and pressure to pull troops out of Vietnam escalated (Scott). Army Lt William Calley was the only soldier convicted and sentenced to life in prison for his role in the My Lai Massacre, although he insisted that he was only following orders from his Captain. Army nurse Kathleen Splinter gives an account of American response to the massacre upon her return from Vietnam:

The first time I had ever heard “baby killers” was when I was working. I worked at Massachusetts General here in Boston and people would talk about, “Oh, they’re just baby killers,” and I would be absolutely stunned. It was such a surreal world to come back to, with all of the sights and sounds and smells of a large city when you’re used to this very small compound where it’s the same thing day in and day out. When I first came home, the My Lai trial was going on, and in fact, My Lai wasn’t very far from Chu Lai where I was. It was like three villages out. Didn’t mean anything to me. I didn’t know that until I got home, but Calley was on trial and even my family said he wasn’t really an American, and there was something wrong with him because Americans don’t act like that. I said, “Excuse me, I don’t think you know what it’s about,” that that wasn’t the only occurrence, and I’m sure it happened in other wars. Oh no, Americans don’t do that, it’s only the enemy that does that, and I thought maybe I missed something.

(Steinman, 2000, p. 134)

American response to the massacre was quickly followed by disbelief on May 4<sup>th</sup>, 1970, when members of the Ohio National Guard opened fire on students on the Kent

State campus, resulting in the deaths of four students and the wounding of nine others. The students were protesting the invasion of Cambodia, which President Nixon had initiated only days before, and had been shouting “Pigs off campus” at the guardsmen - throwing rocks and taking an aggressive stance against the guardsmen who knew little about crowd control and who were exhausted from having just come from patrolling a Teamsters strike (Koerselman, 1987). In response to the massacre more than a million students walked out of their classrooms, briefly shutting down hundreds of high schools, colleges, and universities across the country.

As Nixon began scrambling to bring order to the chaos, in June of 1971 the New York Times started publishing leaked excerpts of a study prepared by the Department of Defense examining American political and military involvement in Vietnam from the past three decades (20<sup>th</sup> Century Day By Day, 2000, p.1035). Termed the Pentagon Papers, the documents revealed that exactly when President Johnson was promising Americans that he would not expand the Vietnam conflict, unbeknownst to them, air strikes over Laos, raids along the coast of North Vietnam, and offensive actions by the U.S. military were taking place (“Vietnam War,” 2007). Deciding that Nixon had been just as dishonest as Johnson in his handling of the Vietnam crisis, both having promised peace and healing and a quick end to the conflict, American’s joined together in the spurning of their Commander-in-Chief demanding an end to the war.

In January of 1973, President Nixon announced to the world that all U.S. troops in Vietnam would be withdrawn, and all offensive actions against North Vietnam would cease immediately (“Vietnam War,” 2007). As soldiers began returning en masse from

Vietnam, they were met by angry and disillusioned Americans who had weathered, over the decade, a series of economic, political, and social changes unlike any other in America's history. Excessive spending on arms had created massive production inefficiencies and for the first time since WWII American's trade surplus disappeared (Koerselman, 1987). Between December of 1968 and May of 1970 Wall Street had experienced a 36 percent decline in the market, with aerospace, airlines, and home furnishings stocks falling from 50 to 69 and a half percent (Koerselman). By 1973 these stocks were only just beginning to recover. Americans were locked in an economic crisis with increasing inflation and concerns over employment. The middle class had had enough. They simply wanted to forget about the war and all of the domestic social welfare issues which had overwhelmed and defined the 1960's. They were ready to move on.

Unlike soldiers from previous wars who were welcomed back as heroes, many who disembarked from military planes in the late 1960's and early 1970's were treated like criminals by civilians and health care professionals alike (Steinman, 2000). Mental health professionals became overwhelmed with the numbers of soldiers seeking services, and the VA was no exception. Statistics from WWII and the Korean War illustrated that incidence of combat related trauma increased as combat intensified, and as the wars wound down so did the numbers of soldiers seeking such services (Scott, 1993). Expecting the same statistical response to the winding down of the Vietnam conflict, the VA had become pre-occupied with treating chronic medical problems that had to do with their aging WWII veterans and was unprepared for the large numbers of returning young

Vietnam vets seeking treatment, rehabilitation, and disability compensation for their injuries (Scott, 1993, p. 8). Statistics related to the much higher wounded-to-killed ratio in Vietnam compared to previous wars had been overlooked (Scott). Their numbers today make up one-third of the membership of Disabled American Veterans which was founded in 1920 (Disabled American Veterans, 2007).

Captain Max Cleland, a signal corps officer with the 1<sup>st</sup> Calvary Division, is quoted in Wilbur J. Scott's *The Politics of Readjustment: Vietnam Veterans Since the War* (1993) discussing the physical and psychological aspects of readjustment as experienced through the VA. Captain Cleland lost both of his legs and his right arm after picking up a grenade which had fallen from his web gear and exploded during a helicopter landing.

It was quickly impressed upon me that in the ... VA a patient is known by his "claim" number, not his rank or branch of service... My ...treatment this day resulted in a two-hour wait after which an attendant handed me a pair of light green pajamas. "You're going up to your ward now," he said. "You are to take no personal effects, no food, no TV and no radio up there. Understand?" I nodded, wondering if I had been dropped off at a federal prison by mistake. An elevator carried me to a higher floor where I was wheeled into a large ward and pushed up next to an empty bed. I was stunned. Most of the men in the ward were 20 or more years older than I...it was obvious that these men had not the slightest inkling of what service in Vietnam had been all about.



To the devastating psychological effect of getting maimed, paralyzed, or in some way unable to reenter American life as you left it, is the added psychological weight that it may not have been worth it, that the war may have been a cruel hoax, an American tragedy, that left a small minority of American males holding the bag.

The inevitable psychological depression after injury, coupled with doubts that it may not have been worth it, comes months later like a series of secondary explosions long after the excitement of the battlefield is behind, the reinforcement of your comrades in arms a thing of the past, and the individual is left alone with his injury and his doubts. Anyone who deals with a Vietnam returnee, wounded or not, must understand this delayed, severe psychological symptom. And, in my opinion, more effort has to be made, especially by the VA, to insure that the ... Vietnam returnees in VA hospitals have adequate...help...in readjusting to American life. (pp. 10, 11)

As Vietnam veterans continued to seek healing they also sought to change the inadequacies of the system. They created informal rap groups which provided them opportunity to ruminate about their war experiences and discuss political agendas (Scott, 1993). As their voices became stronger and their support in the halls of Congress became more formidable, recognition and acknowledgement of their service, and their pain, was realized. Understanding from the medical and military community that onset of traumatic symptoms could be delayed was part of a major victory for the veterans and gave

credence to their experiences (Herman, 1992). The fact that symptoms of combat-related trauma could have delayed onset also questioned the role of the family and interpersonal relationships in its pathology.

While the 1970 discovery of Lithium for the treatment of manic depression and bipolar disorder once again supported the division of biological psychiatry, the work of psychologists, clinical social workers and other mental health professionals steered research and academia towards the possible impact that interpersonal relationships had on maintaining and eliminating war-related psychological and physical problems (Bey, 2006; Stanton & Figley, 1978). Treating the Vietnam veteran within the family system was an innovative approach, and therapists were most likely influenced by the works of John Bell at Clark University, Murray Bowen at NIMH, Nathan Ackerman in New York, and Don Jackson and Jay Haley in Palo Alto; the pioneers of family therapy (Nichols & Schwartz, 2005). Individuals practicing family therapy with returning veterans believed that war-related problems served a vital purpose in the interpersonal system and to treat the problem outside the system would do “more harm than good” (Stanton & Figley, p. 283).

Practitioners of community psychiatry and family therapy had come to understand the importance of interpersonal environment on the health and well being of patients. It had taken more than fifty years for psychiatry and mental health to recognize what social worker Mary Richmond had adhered to in 1917 (Nichols & Schwartz, 2005), in her book entitled *Social Diagnosis*:

As society is now organized, we can neither doctor people nor educate them, launch them into industry nor rescue them from long dependence, and do these things in a truly social way without taking their families into account. Even if our measure were the welfare of the individual solely, we should find that the good results of individual treatment crumble away, often, because the case worker has been ignorant of his client's family history. (p. 134)

Whereas psychiatrist George Engel in the 1970's was considered the father of the biopsychosocial model, Richmond herself was well versed with the concept that biological, psychological, and social issues must be examined in order to improve prognosis (Richmond, 1917). Erik Erikson, in *Childhood and Society* (1950), also makes reference to this ideology in treating combat-related trauma:

We could say with reasonable assurance that this man would not have broken down in this particular way had it not been for the conditions of war and combat – just as most doctors would be reasonably certain that young Sam could not have had convulsions of such severity without some “somatic compliance.” In either case, however, the psychological and therapeutic problem is to understand how the combined circumstances weakened a central defense and what specific meaning the consequent break down represents. (p.44)

While Richmond's early writings indicated the importance of a holistic approach during assessment and intervention, and Erikson demonstrated that combat exposure associated with World War II promoted the integration of the psychological, social, and biological approaches to treatment, focus on the interpersonal aspects of intervention after Vietnam

certainly assisted in formulating the biopsychosocial model of illness and wellness as we know it today. Treatment, like combat-related trauma itself, was evolving.

*The Aftermath*

Vietnam War Memorial

A wall gives structure.

It can divide and block.

It can support and fortify.

It can be a place to display

Photos, writings, awards,

And memories.

But this, is The Wall.

The Wall that gives structure

To the insane losses of a war.

The Wall that represents

A nation divided and blocked.

The Wall that supports too

Many broken hearts and bodies.

The wall that fortifies the reality

Of dead lives among the living.

The Wall that reflects memories

Of what was, of what is,

Of what might have been,

In photos, in letters and poems,  
In medals of honor and dedication,  
And in teddy bears, and flowers,  
And tears and tears and tears.  
This is The Wall,  
Born out of pain and anguish  
And guilt,  
That gives names to the children  
Of grieving mothers and fathers  
And to the spouses of widows  
And to parents of wondering children.

This is The Wall  
That echoes sadness and fear,  
Yet whispers relief and hope.  
This is The Wall.  
May we be forever blessed by its  
Structure and fortitude and support,  
And may we be forever reminded  
Of the eternal divisions of war.

Mattie J.T. Stepanek – February 2000

The Vietnam Veterans Memorial in Washington, D.C. is a solemn reminder of the fallen men and women who served. While the wall makes no political statement with

regards to right or wrong, it's mere existence acknowledges and values all who bravely fought for a cause in which they believed. Standing stark against the Washington landscape, larger than life and magnificent in scale, the wall demands respect. In order to read the inscribed names of the deceased one must stand 6 feet below the horizon "conversing in the space of the dead" (PBS Home, 2005). "When I looked up at the sight...I wanted something horizontal that took you in, that made you feel safe within the park, yet at the same time reminding you of the dead. So I just imagined opening up the earth..." Maya Yin Lin, designer of the Vietnam Veterans Memorial (Scott, 1993, p. 129).

Within the two years it took to approve, build and complete the two 247 foot black granite walls, many additional milestones transpired attempting to end the bitter divide among Americans regarding the war. The Vietnamese government extended an initial invitation to the Vietnam Veterans of America to travel to Hanoi in order to discuss the lasting effects of Agent Orange, and the possible whereabouts of American POW's (Scott, 1993). While the delegation returned to intense criticism among fellow veteran representative groups, those who went described the visit as a catharsis. "The war is over, really over for me. I went through some anxiety when I came here. I was nervous as hell...But now we're dealing with issues, we're dealing with reality, not the past" (Tom Bird, quoted in Scott, 1993, p. 146). Additional invitations to visit Vietnam ensued and many veterans' groups followed through.

Attempts to fix problems associated with the GI Bill were also an effort to heal veteran perceptions that WWII soldiers had received much greater support during

reintegration then those returning from Vietnam. WWII veterans had received up to \$500 per school year for 4 years which covered full tuition at some of the best private universities in the U.S., with an additional \$50 per month to cover living expenses (Time Magazine, 1973). In the initial stages of the Vietnam War the government did not even consider a peacetime GI Bill, believing that social policy changes which had been made in the early 1960's negated such benefits (Shafer, 1990). When Johnson finally signed the bill in 1966, it was noted by critics that the government had allocated only \$150 per month, per veteran, to cover tuition as well as living expenses (Time Magazine, 1966). "It offered exactly the same benefits World War II veterans received – despite the doubling of state college tuitions and the quadrupling of private college tuitions" (Shafer, p. 96).

Under pressure from veterans groups in an effort to repair the disservice congressional leaders intervened, demanding an increase in veterans' benefits. Between 1967 and 1977 several bills were presented to the House that would raise the monthly allowance rate, but before the legislation could be implemented rates were often reduced, sometimes by half their proposed amount, and the struggle for adequate compensation continued (Shafer, 1990). As funding slowly increased, corresponding numbers of veterans entering universities, college, and technical programs also increased. By the end of the program 65 percent of Vietnam veterans (more than 6 million), had used their education benefits compared to 51 percent from WWII (Time Magazine, 1979).

While millions of Vietnam veterans went on to distinguished careers in a variety of fields many felt that the government had failed to truly provide for them in their time of need, and the stigma associated with service in Vietnam suggesting that all veterans

were “angry, alienated, semiliterate and drug-prone” made reintegration particularly difficult (Time Magazine, 1979, p. 1). Due in part to stereotyping such as this, it took several years for the field of mental health to formally acknowledge the unique combat-related trauma symptoms of Vietnam veterans, and recognition and reimbursement for after-effects suffered from the wide-spread use of Agent Orange is still ongoing.

It is completely plausible that in American refusal to share in the responsibility of the atrocities committed during the Vietnam War, a homecoming was created for their veterans unlike any other in American history; indirectly contributing to the increase in combat-related trauma cases experienced. Never before had America endured such a long and divisive war, and never before had she known such defeat. Domestic and international stakes had been high, and the social, political, and economic costs substantial.

Of the more than 8 million living Vietnam veterans, many have had the opportunity to visit the Vietnam Memorial in D.C. and pay their respects to fellow soldiers, nurses, servicemen, and servicewomen who lost their lives during the conflict. To the men and women whose lives were shaped by their participation in this mighty battle, the Wall is more than a place of mourning; it serves as a reminder of the brutalities of war, and its message is one of hope.

[We] were met by the temporary board fence that surrounds the site... We walked through the usual litter of a construction site, and gradually the long walls of the memorial came into view. Nothing I had heard or written had prepared me for that moment. I could not speak. I wept.



There are the names. The names! The names are etched in white on polished black marble. The names are arranged chronologically by the date of death, running from July 1959 to May 1975.

For 20 years I have contended that these men died in a cause as noble as any cause for which a war was ever waged. Others have contended...that these dead were uselessly sacrificed in a no-win war...Never mind. The memorial carries a message for all ages: this is what war is all about.

On this sunny Friday morning, the black walls mirrored the clouds of summer's ending and reflected the leaves of an autumn beginning, and the names - the names! - were etched enduringly upon the sky.

James Kilpatrick (Quoted in Scott, 1993, p. 159)

CHAPTER VI  
WAR IN THE 21ST CENTURY

*“There are places even in Fallujah where the street song drops away to nothing, shaded alleys devoid of sound: you step inside them and for a moment it seems like nothing outside could ever get to you. Keep your steps right and you could let the patrol you are with get just far enough ahead to leave you out of earshot and with nothing but your thoughts and for a brief time you could begin again to feel human, like something approaching whole. But the war never leaves you. It is always here, stalking you like a shadow...In the quiet times, in the middle of long hot patrols you can’t help wondering what this place was before it became the dark muse of the American military.”*

*David J. Morris, former U.S. Marine*

*(The Big Suck: Notes from the Jarhead Underground, Al Anbar Province, Iraq, 2006, p. 145)*

When Operation Enduring Freedom (OEF) broke out in Afghanistan a few short weeks after the terrorist attacks of September 11, 2001, Americans were intent on revenge. Shock, outrage, and disbelief that Americans could be vulnerable on their own soil was felt by U.S. citizens around the globe, and they came together in their grief to support the families who had lost loved ones in the attacks. Reminiscent of Pearl Harbor, this assault was only the second time in modern history that foreigners had dared to attack America on her own soil, but the similarities ended there. Carried out by militants independent of any flag, country, or nation, the attacks were years in the making and had one goal in mind: kill as many civilians as possible in order to demonstrate that America

was no longer safe from those who wished her harm. Believing that Afghanistan was both harboring and supporting the terrorists, Americans quickly rallied in defense of OEF, and when the U.S. government produced “evidence” that Iraq’s hands were also dirty, America resoundingly endorsed Operation Iraqi Freedom (OIF) launched in 2003. At the time of this writing the war in Afghanistan is entering its sixth year, and OIF has been ongoing for more than three. In both wars over 3,800 American soldiers have been killed (Department Of Defense, 2007), and an excess of 50,500 service men and women have suffered from non-mortal wounds (Bilmes, 2007).

While it is not the intent of this chapter to either review or synthesize the war on terror from its early roots to its present day understanding, or dissect the various political actions which have contributed to its current manifestation, comprehension surrounding the war’s impact on treatment, methods, explanations, and outcomes of combat-related trauma is pertinent to our subject matter. Thus, as in prior chapters, events pertaining to the economic, social, and affairs of state, relevant in furthering our understanding of how combat-related trauma evolved during the latter half of the 20<sup>th</sup> century, will be examined. Personal vignettes of soldiers who have served, issues relating to reintegration, and current military protocol will also be considered in order to appreciate the etiology and pathology of PTSD as we have come to understand it in the 21<sup>st</sup> century.

#### *America in the 1970's*

Politicians and Americans alike view the 1970’s as a transitional era featuring Richard Nixon, Gerald Ford, and Jimmy Carter as relatively moderate U.S. presidents who laid the foundation for the conservative counterrevolution of the 1980’s (Jansson,

2005). People were fed up with Vietnam and social reform issues and the middle class had become engrossed with new concerns such as inflation, unemployment, increasing crime rates, and government spending (Jansson). Many of the reform groups intent on changing the status quo for African Americans and the disadvantaged were now perceived as militant and fundamental in their tactics, and numerous white Americans began to resentfully view advances made by such underprivileged groups as unfair and disproportional (Jansson).

Using this changing perspective to his advantage during his second term, Nixon rejected attempts for new social legislation, and proceeded to deny ensuing discretionary funding for social and educational programs. Believing the democratic party to be partial to special interest groups, Nixon and his Vice President, Gerald Ford, managed to polarize the House of Representatives by cutting federal funding on existing social programs, reneging on funds already earmarked by Congress, threatening to decrease the federal workforce, and placing into office right-wing conservative representatives whose agendas seemed to mirror their own (Jansson, 2005). The Watergate scandal was the icing on the cake in terms of presidential credibility. While Ford reigned briefly after Nixon's resignation, his presidency did little to change the direction in which the country was destined.

Despite the lack of political support and cooperation, oppressed groups rallied to obtain autonomy and share in the riches of American society. Gay Americans began to openly acknowledge their sexuality and began to organize in attempts to end discrimination encountered in the military, the workforce, and other areas of life. African

Americans utilized their right to vote, earned advanced degrees, and began entering into the middle class. They also garnered a foothold in the white power structure and began to slowly chip away at prejudices, stereotypes, and injustice. Public education and environmentalism were two of the hottest subjects among Americans, with crusades for better schools and clean air, clean water, and biodegradable products becoming headline news (Woods, 2005). American women concerned with issues of equality also began to re-organize, and became part of a second wave of activists who were smarter and less radical in their approach, attempting to appeal both to conservatives and liberals alike.

In 1970 only 44 percent of American women were employed, but as the years progressed their numbers continued to grow, and by the end of the decade 51 percent had entered the workforce (Woods, 2005). Advancement was not easy, and for each issue needing addressing organizations formed in order to develop their transformation. Job discrimination, equal pay, maternity leave, child support from absentee fathers, reform on state and federal rape laws, and increased funding for battered women shelters were all tackled with passion and the help of strong legal teams and renewed organizational efforts (Jansson, 2005). Campaigns for liberation and equality attempted to raise the majority's conscience, but conservatism was fast becoming engrained among those who considered decisions such as *Roe vs. Wade* a moral outrage.

Throughout the 1970's veterans from the Vietnam War experiencing the difficulties of reintegration continued to fight for recognition of their symptoms which appeared to escalate upon their return home. Post-Vietnam there began an inundation of research studies concerned with the psychological effects of combat and potential

treatment paradigms. But these studies did not originate through military or medical channels, instead, they stemmed from the efforts of Vietnam veterans who had been negatively affected by the war (Herman, 1992). The Nixon government was not interested in the mental health problems of Vietnam vets – they only served to remind the administration of a failed war. Veterans were forced to advocate on their own behalf for treatment and disability services, and they did so through the formation of informal rap groups which provided necessary support with their symptoms while raising awareness of the effects of combat. As the groups increased in numbers and strength their political influence became significant, resulting in official recognition of post-traumatic stress disorder in 1980 in the DSM-III.

The DSM- III publication was “a radical departure from DSM-II (1968), in that it was explicitly atheoretical and steeped in descriptive psychiatry based on observable symptoms rather than psychodynamic constructs” (Gabbard, 2000, p. 108). The publication’s change in focus was a result of psychiatry’s interpretation throughout the 1960’s and 1970’s that scientifically rigorous work, with regards to observable patient symptomatology, was much more methodical and would be taken more seriously within the realm of medicine than would clinical work based on feelings, fantasies and changing cognitions (Gabbard). With emphasis on phenomenological perspective and scientific study, cognitive-behavioral therapy (CBT) was born and would impact the treatment of mental illness, including combat-related trauma, well into the millennium with its focus on measurable adherence to therapy.

As politics continued to evolve throughout the 1970's and early 1980's, the chasm between liberals and conservatives continued to grow. While democratic candidate Jimmy Carter managed to secure the U.S. presidency by a narrow margin against Ford in 1976, a divided Congress, soaring oil prices, and continuing economic stagnation crippled his attempts at establishing much of his social policy agenda throughout his tenure. His wife, Rosalyn Carter, attempted to shine light on issues relating to mental health by establishing a Presidential Commission on the subject early into her husband's presidency. Unfortunately, while the commission cited problems such as lack of insurance coverage in outpatient visits and inadequate community mental health services for the elderly, adolescents, and individuals with chronic mental illness, no major reforms evolved as the Mental Health Systems Act of 1980 did not provide community mental health centers with the monetary means to implement the new services in which it mandated (Jansson, 2005).

Perceived as doing little to jump-start the economy and control the high rate of inflation, Carter quickly lost support among those who had elected him to office and widespread public disenchantment with government took on a whole new meaning. His inability to end the Iranian hostage crisis, which lasted from November 4, 1979 through January 20, 1981, emasculated his presidency and his hopes for re-election. During his presidency military spending had declined from 8 percent of the national product (GNP) in 1966, to 5.5 percent of the GNP in 1981, but social spending had reached an all time high despite few new projects or reforms (Jansson, 2005). Social policies enacted in the 1960's and early 1970's, such as the indexing of Social Security, the federalization of

Food Stamps, revenue sharing, and the Comprehensive Employment and Training Act (CETA) had led to an increase in federal social spending from \$67 billion in 1960, to \$314 billion in 1980, with little to show for it in the field of mental health (Jansson).

While the reform movements were certainly helping the poorest of the poor, they did little to alleviate the woes of the blue collar working class fighting for increases in minimum wage, or the fact that unionized, manufacturing jobs were fast disappearing, public education was sorely lacking, and rising costs were devastating the U.S. economy (Jansson, 2005). Carter's last minute attempt to balance the budget by raising discount rates, trimming government spending, and tightening the money supply did little to lift the flagging spirits of Americans already disillusioned in government by way of Vietnam and Watergate (Woods, 2005). When conservatives finally came to power in the 1980's, the "Me Years" were born, and Americans turned their backs once again on civic action and social justice (Woods).

#### *America in the 1980's*

On January 20, 1981, moments after Ronald Reagan was sworn in as America's 40<sup>th</sup> President, the Iranian hostage situation came to an end and the hostages were released into U.S. custody. Americans, exhausted after having watched the crisis unfold for more than a year, looked to Reagan to revive their spirits and lead them patriotically back into the fold. Often referred to as "the great communicator," Reagan's commanding presence coupled with his eloquent and compelling verbiage offered Americans a commander in chief that was not afraid to make decisions or stand out on a limb for his convictions. Reagan once said "I never thought it was my style or the words I used that



made a difference: It was the content. I wasn't a great communicator, but I communicated great things..." (BBC News, 2004). For good or bad, one of the Reagan administrations most coveted policies surrounded supply-side economics. Young, urban professionals (i.e., "Yuppies") were the most avid supporters of its low-tax, anti-regulation policies which allowed them to devote their lives "to securing and retaining well-paying jobs and enjoying an affluent lifestyle" (Woods, 2005, p. 460). With little interest in community action or social consciousness, these young professionals favored their BMW's, gourmet restaurants, and high-tech lifestyles (Woods).

Evidence of a society intent on individualism and self-absorption can be found in various cultural markers throughout the 1980's and 1990's. The physical fitness craze whereby middle class Americans spent endless hours in the gym perfecting their bodies through running, cycling, and stretching, was duplicated in films such as *Perfect*, starring Jamie Lee Curtis, which grossed over 12 million at the box office in 1985 (The Movie Times, 2007). Television programs examining the dysfunctional lifestyles of the rich and famous such as *Dynasty* and *Dallas* were the highest rated shows of their day. Daytime talk shows were the rage, as were magazines such as the National Enquirer and People Magazine which explored the private lives of "the functional and the deviant" (Woods, 2005, p. 443). Werner Erhard, whose Erhard Seminars Training (EST) classes taught self esteem and the value of "power relationships" enrolled 6,000 people per month at its peak and advertised "You are the one and only source of your experience. You created it" (Woods, p. 444).

In recognizing individual empowerment as a “cure-all” for those individuals who were struggling with life and felt unfulfilled and unmotivated, the self-help movement was born. Author of the book *SHAM: How the Self-Help Movement Made America Helpless* (2005), Steve Salerno writes that the self-help concept can be broken down into two camps – victimization and empowerment. Authors and movements touting victimization sell the “idea that you are *not* responsible for what you do (at least not the bad things)” (p.26), while those who spout empowerment take the opposite stance whereby “you are *fully* responsible for *all* you do, good and bad” (p. 26). After Vietnam, Salerno contends that people were happy to see themselves as victims in a culture “with its backstory writ of excuses and alibis” (p. 27). Playing into this sentimentality was/is the position that the diagnosis of PTSD was established in order to view combat veterans from Vietnam as victims, instead of perpetrators, to Americans dismissive of their service. Salerno quotes Dr. Sally Satel, who candidly criticizes the APA and AMA for “openly devis[ing] convenient syndromes and talk[ing] about them as if they were uncontested medical fact...whether [or not] there was any clinical evidence for it” (p. 31).

While PTSD should not fall into this realm considering the amount of research conducted which supports etiology, pathology, and symptomatology, the diagnosis of the illness, critics argue, serves more of a litigious purpose than a clinical one. With PTSD there is a clear stressor which can be identified as the cause of individual functional impairment and ensuing symptomatology. Because this incident must be clearly defined in order to receive diagnosis, there is a liability associated with its identification which

can result in legal issues, disability claims, etc. While clinicians can argue that just because there is misuse of the construct does not mean the construct is not valid, the diagnosis continues to receive massive media attention; risking over-diagnosis much like ODD became a catch-all finding for many disagreeable children in the 1990's.

Salerno contends that while empowerment has developed the new message that each individual can be the master of their own universe and can overcome all obstacles in life, it also alludes to the idea that if someone is struggling to overcome odds, or cannot seem to dig themselves out of a hole, it is because they do not have the necessary desire or commitment; they are deemed "unworthy." A different label, perhaps, than that which was attached during the age of eugenics and social Darwinism at the turn of the century, but one which certainly radiates similar connotations. For many soldiers returning from Vietnam who found reintegration overwhelming and dissatisfying, their inability to "conquer the world" and take charge of their "inner demons" left them feeling like failures.

With such intense focus on individual needs, any American concerns related to global issues in the latter part of the 20<sup>th</sup> century were dealt with from a distance. When Americans first heard the term "war on terrorism" in the 1980's it was articulated by U.S. president Ronald Reagan in relation to a series of terrorist attacks against Americans on international soil. The Iranian hostage crisis had come to an abrupt end when Reagan took office, and while the hijacking of the Italian liner *Achille Lauro* briefly entered American living rooms via satellite, it left just as quickly. The reality, however, was that terrorism against Americans was fast becoming a military and political concern; in 1985

alone, 17 Americans were killed in terrorist attacks in foreign countries and another 154 were wounded (Woods, 2005). While Reagan continued to increase military spending for his Strategic Defense Initiative (i.e. “Star Wars”), any fears Americans may have had over the ongoing Cold War virtually ended in 1989 with the collapse of the Berlin Wall. It would not be inaccurate to suggest that a false sense of security permeated throughout the U.S. during this time with regards to global terrorism. Even when the Gulf War broke out on the evening of January 16th, 1991, Americans sat in front of their television sets and watched the tracer fire light up the skies around Baghdad almost as though it was the choice of entertainment for the evening. More than 200 soldiers lost their lives in the conflict, and over 450 more were wounded (Office of Public Affairs, 2003), but the conflict ended almost as quickly as it had begun and Americans lost interest despite the fallout of Gulf War Syndrome.

#### *America in the 1990's*

Within a year of the Gulf War a sharp economic downturn hit the U.S. and in 1992, during the month of December alone, Xerox, General Motors, and IBM cut their workforce by 100,000 (Woods, 2005). A ballooning deficit left over from the Reagan years, along with the S & L bailout and a rising trade imbalance, created a crisis of confidence among Americans which could be seen in their extremely low rate of reinvestment of their GNP into the economy; approximately 15 percent (during this same period the Japanese were reinvesting 31 percent) (Woods). The population of young, urban, professionals was aging and generating new concerns about unemployment, lack of universal high-quality health care, and increases in crime rates. In 1992 Americans

chose William Jefferson Clinton to become the forty-second President of the United States after his promise to reduce the federal deficit and shift funds from defense to necessary social, educational, and anticrime programs (Woods, 2005).

While Clinton sought to have liberal policies enacted during the first few years of his presidency, dissatisfaction with continued escalating crime rates and a perspective that he was doing little to change the status quo, resulted in a landslide victory for Republicans during the midterm elections in 1994 (Woods, 2005). Despite the slight, Clinton continued to fight for the disenfranchised and was successful in maintaining pregnant women's right to choose, continuing affirmative action at the federal level, expanding Head Start, and creating tax concessions to fund education for low and moderate income adults (Jansson, 2005, Woods). Clinton was also able to extend health insurance to children not covered under Medicaid, which was a major victory for democrats, along with new laws forbidding private health insurance companies to discriminate against mental health in their policies (Jansson). Conversely, his plan to provide universal health care coverage for all Americans was seen as complicated, meeting with disapproval from influential conservatives, the American Medical Association, and private insurance companies, the plan never passed a House vote (Woods).

During the latter half of the 1990's America experienced an economic boom, in large part brought about by the "dot com" world of high tech companies involved in the expansion of the Internet (Woods, 2005). Before the bubble burst at the turn of the millennium, Americans were enjoying the lowest unemployment rates since the early

1970's, and with mortgage interest rates below 7 percent, home ownership rose to an all time high of 66.8 percent, with blacks and Hispanics among the biggest gainers (Woods). In an effort to show he was tough on crime, Clinton pushed through the House a crime bill allocating the additional hiring of 100,000 police officers and shortening the appeals process for convicted death-row inmates (Woods). Clinton's administration also managed to reduce the federal workforce by 250,000 employees contributing to a 60 percent reduction in the federal deficit (Woods).

Despite all of the administrations success, President Clinton's second term in office was marred by scandal, and Americans became somewhat disillusioned with his government and the very nature of American politics (Woods, 2005). The Whitewater investigation pertaining to a land development project southwest of Little Rock, Arkansas and charges of presidential sexual misconduct leading to charges of impeachment had opened the door to Clinton's conservative opponents in the forthcoming Presidential elections. Republicans were quick to add "immorality" to their list of liberal grievances, which already included allegations that Democrats were "soft on defense, agents of big government, and tax-and spenders" (Woods, p. 537).

During the lead-up to the elections, Americans had also become more aware of issues pertaining to terrorism. The bombing in Oklahoma City had shown that America could be vulnerable to violent home-grown extremists, and media coverage of the "Unibomber" had served to drive home the message. Swept up in the conservative language touting "family values," in 2000 Americans voted into office George W. Bush – a God fearing man who spent his Sundays in the first pew, and welcomed support from

the Moral Majority who fought to outlaw abortion, return prayer to the schools, and restore dignity to American politics (Woods, 2005). Less than a year after Bush set foot in office the September attacks occurred and America found herself, once again, at war.

*The New Millennium - The War on Terrorism*

While the war on terrorism, the war against terror, and the war on terror, refer to many different conflicts over time, since the millennium the terms are indicative of the U.S. governments response to the September 11, 2001 attacks on the U.S., in which al-Qaeda claimed responsibility. Both OEF, launched in Afghanistan in October of 2001, and OIF, launched in Iraq in March of 2003, commenced in retaliation of the al-Qaeda assault and are ongoing at the time of this writing.

Many features of OEF and OIF make them unique. The individual make up of soldiers serving; length of deployment, repeat deployment, and heavier exposure to urban guerilla combat; technological advances in warfare; and the wounded-to-kill ratio of soldiers compared to prior wars all set the ongoing conflicts in Afghanistan and Iraq apart. When Congress adopted the concept of the all volunteer force (AVF) at the end of the Vietnam War, the plan was to recruit individual volunteers to serve in active duty status for a pre-determined period of time, and to utilize members of the National Guard and Reserves alongside the active-duty forces when necessary (Ensign, 2004). There were many arguments waged against the move including those pertaining to cost; concerns with a potential lack of flexibility among volunteer service members; the possibility that individuals from lower socio-economic levels would be more inclined to enlist because of monetary and educational incentives; and apprehension that the quality

of servicemen would decline given the feasibility that they would be more interested in acquiring skills training or a college education as opposed to engaging in warfare (Ensign). Despite the legitimacy of such arguments, the AVF was enacted in 1973 and the historical policy of conscription came to an end.

While the AVF was generally successful for several years, the combination of generous salaries, re-deployment bonuses, and college loan payments eventually contributed to an already swollen military budget, and in 1990 the Pentagon cut the active-duty force from 2.1 million to 1.4 million (Ensign, 2004). The Cold War had also come to an end, justifying the cutback, with Guard and Reserve units also downsized but to a much lesser degree (Ensign). When the Persian Gulf War broke out, it was waged over a relatively short period of time, supported by coalition forces, and aided by technologically advanced weaponry that could be launched at the touch of finger from airplanes and ships located several miles away from military targets. AVF were able to liberate Kuwait and finish their assignment well before attrition set in. Regrettably, OEF and OIF have proven to be very different conflicts.

The wars in Afghanistan and Iraq have been lengthy in comparison to the Persian Gulf conflict, and the AVF has been stretched to capacity. To date, 1.4 million U.S. servicemen and women have been deployed to Afghanistan and Iraq (Bilmes, 2007), with approximately 150,000 troops currently based in the region consisting of 43 percent active duty personnel and 57 percent Reserve and National Guard members (Figley, 2006). One in every six GI's on active duty today is female, with women constituting approximately 15 percent of the Navy and Army, 20 percent of the Air Force, and 5



percent of the Marines (Ensign, 2004). Women also fill 90 percent of all job categories in the U.S. military (American Psychological Association, 2007).

One such soldier is Lt. Maria Kimble, who served as an Army mental health worker in Iraq from April of 2005 to April of 2006. Her story is documented in *What was Asked of Us: An Oral History of the Iraq War by the Soldiers Who Fought It* (Wood, 2006):

There were quite a few suicide bombings in Tall Afar. Soldiers weren't injured, because suicide bombers were targeting people that were going to sign up to be a part of their police force or people going to vote, but there were mass suicide bombings where thirty or more people were killed. The soldiers had to witness it and clean up the aftermath... Could you imagine being an eighteen-year old private and having to go clean up thirty bodies that were just blown apart, picking up an arm here, a leg there, and putting arms in a pile and legs in a pile, then trying to figure out what goes with what body? It's extremely traumatic. The biggest concern soldiers had was seeing the children. Children were blown so high that they would land on the roofs of buildings, and soldiers had to go and retrieve the bodies. They said that really affected them, mostly because they had children of their own...

[Many times] I would just hitch rides on re-supply vehicles, and that would get me out to where the soldiers were engaging the enemy. They had set up patrol bases in Tall Afar, so that's where I would go when I could. I would go out with

the field artillery guys who provided security, maybe stay a day or two, and then come back in any way I could. I would hop on the Black Hawk medical helicopters that were used for transferring soldiers, or any other way I could get out there to the soldiers. Many health professionals won't go outside the main bases because they are afraid, but being prior military – meaning I was enlisted for so many years and had many different jobs – I view myself as a soldier first. If an infantry soldier can go outside the wire, I should be able to as well.

(pp. 287, 288, 290)

As increasing numbers of women continue to enlist throughout all branches of the U.S. military, cases of military sexual trauma (MST) have become more prominent. The abuse of women at Tailhook in 1991, along with the publicity surrounding numerous sexual assault allegations at the Air force Academy in 2003, has created much more awareness surrounding the prevalence of MST, but numbers do not seem to be dissipating. Between September of 2003 and February of 2004, the U.S. military received 112 reports of sexual misconduct, including rape, from female soldiers serving in Iraq, Kuwait and Afghanistan (Schmitt, 2004). Corroborating these numbers at a slightly higher rate, the Miles Foundation, which is a private, nonprofit organization providing assistance to victims of violence associated with the military, reported 129 credible accounts of military sexual assault in Iraq between November of 2003 and April of 2004, and 347 reliable reports of military sexual assault associated with U.S. military installations (McHugh, 2004).

In an effort to respond to the increasing number of MST cases, a Congressional Task Force on Military Domestic Violence responsible for examining the scope of the problem came up with the following recommendations in 2003: Firstly, the military needed to establish a confidential reporting system protecting the victims against retaliation; secondly, abusers needed to be subject to the criminal justice system for punishment instead of the military's administrative policies which did not allot for criminal conviction or jail time; thirdly, intervention teams needed authorization to investigate complaints of sexual abuse and to act as advocates on behalf of the women; and lastly, investigative resources needed improvement, including forensics, in order to be more prepared in handling sexual assault complaints (Ensign, 2004). As the Department of Defense continues to work at implementing the Task Force recommendations, VA facilities across the country have made several changes to their response to MST. Such facilities are now mandated to perform a universal screening of all veterans (male and female) for possible MST, and facilities must employ a Military Sexual Trauma Coordinator responsible in overseeing screening and treatment procedures (Iraq War Clinicians Guide, 2004).

To further understand the demographics of those currently serving in the U.S. Armed Forces, in his book *What Every Person Should Know About War* (2003), author Chris Hedges states that of the 100,000 volunteers who joined the U.S. Army in 2002, 80 percent were men, 65 percent were white, 18 percent black, 13 percent Hispanic, and the average age was 21.1 years, with 12.1 years of education (p. 11). Hedges also confirms

that 67 percent of individuals who join the U.S. armed services (male and female) do so to fund their education, or for job training.

Most armed services recruits are signed up for a four year active duty period, followed by a few years in the Reserves. In 2005 the U.S. Army reported that it had missed its recruiting goal by more than 27 percent, despite the fact that they were offering the largest enlistment bonuses ever offered: \$20,000 for those willing to sign on for four years (Moniz, 2005). During the same period the Army Guard was almost 24 percent behind its recruiting target, and the Army Reserve was about 10 percent below its projected goal (Moniz). As most ground forces in Iraq are comprised of U.S. Army active duty, Guard, and Reserve members, recruitment shortages at this stage are troublesome for the military and have given way to discussions surrounding the re-implementation of the draft process (Ensign, 2004).

It is not surprising that Army National Guard and Reserve recruitment numbers have fallen off as recruiting problems have plagued these branches for some time (Moniz, 2005). Individuals in the Reserve and National Guard currently find themselves activated for up to 18 consecutive months; creating enormous adversity for individuals and families who were used to training one weekend a month and serving two weeks a year (Ensign, 2004). Reflective of these hardships is the divorce rate among Reserve officers in comparison to active duty officers. One year after OEF was launched, selected Reserve officers had a 3.1 percent divorce rate, almost double the divorce rate of active duty officers, which was reported at 1.6 percent (Hedges, 2003). According to Sergeant Stevens (personal communication, April 26, 2007) of the United States National Guard

based in Houston, Texas, prior to the 9-11 attacks in 2001 Guard members were required to serve no more than one cumulative year for every five years of regular drill; current policy dictates that Guard members can be mobilized for up to 18 months for every three-year enlistment period. Sergeant Stevens noted that this policy is due to change, consequently allowing the President to activate Guard members for 24 month deployment periods every two years.

With regards to the recruitment of active duty personnel, a spokesman for the U.S. Army Recruiting Command at Fort Knox in Kentucky attributed part of the shortfall in recruitment numbers to parental concerns that their children would be seriously injured or killed in Iraq (Moniz, 2005). According to Linda Bilmes, a faculty member at Harvard University's John F. Kennedy School of Government and author of a 2007 study examining the long-term costs of providing OEF and OIF veterans with medical care, parents concerns are legitimate. Bilmes writes (2007) that more than 3000 American soldiers have been killed to date in Iraq and in excess of 50,500 soldiers have suffered non-mortal wounds in both OEF and OIF – a ratio of 16 wounded for every fatality. Bilmes states that this is the highest killed-to-wounded ratio in U.S. history – in Vietnam the rate was 2.6 per fatality, and in Korea it was 2.8. WWI and WWII had an lower smaller wounded per death ratios.

While it is a credit to military medicine that combat survival rates are so high, Bilmes (2007) writes that the type of injuries suffered are noteworthy and indicative of OEF and OIF warfare. Some 20 percent of soldiers have suffered traumatic brain injuries (TBI), spinal injuries, or amputations; and another 20 percent have suffered from

blindness, partial blindness or deafness, and serious burns. The increased use of improvised explosive devices (IED's), otherwise referred to as roadside bombs, has been largely responsible for increases in both death rates and injury rates among soldiers. While IED's were first used in WWII, and were also responsible for many casualties in Vietnam, recent improvements in explosives technology and cellular telephone detonation have made the devices deployable at long distances from the intended target, 50 meters or more, making them even more deadly as they are very difficult to spot and disarm.

Not all IED explosions which affect the brain result in TBI. Many soldiers have experienced multiple explosions whereby they are temporarily knocked unconscious, with no other visible injuries. In these cases soldiers are kept for 24 hour observation and, if they prove able to walk and carry out orders, they are returned to duty despite long-term medical concerns. In a recent (2007) NBC Nightly News broadcast, chief science correspondent Robert Bazell reported on the *Treatment of IED Injuries*, part of a series of reports from Iraq entitled *Wounds of War*. Within the segment Brazell spoke with several medical personnel currently treating soldiers in both Baghdad and Germany. Concerns over long-term issues such as memory loss and sudden emotional changes, as a result of their IED experiences, were expressed. Brazell reported that fatigue, stress, nausea, dizziness and headaches could also be signs that injuries sustained in the blast are more serious than initially suspected, but such symptoms almost come with the territory and are difficult to diagnose in the 24 hour observation period.

Interesting to note – here we are in the 21<sup>st</sup> century examining the effects of the forces of compression and decompression pertaining to IED devices – not unlike physicians during WWI who were searching for etiological explanations of shell shock cases. During WWI physicians initially believed that symptoms were caused by proximity to the explosion which in turn led to microscopic brain hemorrhage. While the explanation was eventually ruled out in favor of a psychological rationalization, with the sophisticated brain imaging equipment of today we can now confirm that microscopic damage to the brain can occur from such devices, which frequently results in symptomatology that is behavioral in nature. TBI symptomatology including detachment, difficulty concentrating, insomnia, restricted affect, irritability, inability to recall important aspects of trauma, avoidance of people, crowded places, activities, and diminished interest are common elements of PTSD and therefore must be screened carefully in order to direct treatment.

Although traumatic brain injuries are an ongoing concern, Bilmes (2007) writes that PTSD rates are also creating apprehension among professionals:

The largest unmet need [of returning soldiers from Iraq and Afghanistan] is in the area of mental health. The strain of extended deployments, the stop-loss policy, stressful ground warfare and uncertainty regarding discharge and leave has taken an especially high toll on soldiers. (p. 11)

Extended deployments are a serious matter to date, with almost one-third of the servicemen involved in the war having been deployed two or more times, and many having served in both Iraq and Afghanistan. The stop-loss policy in which Bilmes refers

to is the military's entitlement to keep soldiers on active duty past their discharge dates. More than 50,000 GI's are in this position today (Ensign, 2004). The Bilmes study reports that more than 36 percent of veterans treated thus far have been diagnosed with PTSD, acute depression, substance abuse, and other mental health conditions. According to a leading veteran's advocate quoted within the research, the signature wounds from OEF and OIF will be TBI's, PTSD, amputations, and spinal cord injuries, with "PTSD [being] the most controversial and most expensive" (p. 11).

As veterans seek assistance for medical and/or mental-health complications they can opt for either private or federal care; albeit the financial costs of any assistance through private health care providers is entirely the responsibility of the veteran. Through the 1980's and 1990's Managed Care became the U.S. answer to health care under the premise that it would lower medical inflation. The growth of Health Maintenance Organizations (HMO's) during these decades, and indeed into the 21<sup>st</sup> century, has been substantial. While their initial premise may have had value, to date coverage has become increasingly expensive and candidates in the current Presidential debates are expressing concern that medical inflation is now two to three times the rate of overall inflation; making health care coverage out of reach for many Americans, including veterans. While veterans returning from Iraq and Afghanistan enjoy unlimited medical coverage within the VA system for two years from date of discharge (if their discharge is denoted as honorable), unless they become service connected during this time (i.e., injury has been equated with wartime experience and is therefore covered indefinitely), after the two year period they become fiscally responsible for a portion of their medical needs.



Eligible veterans seeking help at VA facilities for PTSD related symptoms are offered a wide-array of treatment options - all of which have been discussed extensively in Chapter III of this thesis. As noted, CBT, EMDR, and pharmacotherapy have had the greatest effect on decreasing symptomatology, and research continues to explore etiology and pathology of the disorder. With regards to access of behavioral health services, there are discrepancies between U.S. Military reports and private sources. In the 2006 ( May 29<sup>th</sup>) Mental Health Advisory Team (MHAT – III) report, compiled by the Office of the Surgeon Multinational Force-Iraq and the Office of the Surgeon General of the U.S. Army Command, key findings report that only 5 percent of 1,124 soldiers surveyed reported difficulties in obtaining mental health specialists. The report also suggests that additional findings, when compared with the MHAT II conducted in October of 2004, suggest that the stigma associated with mental health care services has declined among OIF soldiers. Results are based on increasing numbers of soldiers seeking mental health care, reported to be 30 percent in MHAT III vs. 23 percent in MHAT II.

Army soldier Tyler Jennings would strongly disagree with these findings. Not only did he find it difficult to obtain mental health services while serving on active duty in Iraq, when he finally did he was ridiculed by his company commanders – the very people who should have been most concerned with his condition. Daniel Zwerdling, in an NPR article entitled *Soldiers Face Obstacles to Mental Health Services* (2007), reports on Jennings story:

Soldier Tyler Jennings says that when he came home from Iraq last year, he felt so depressed and desperate that he decided to kill himself. Late one night in the

middle of May, his wife was out of town, and he felt more scared than he'd felt in gunfights in Iraq. Jennings says he opened the window, tied a noose around his neck and started drinking vodka, "trying to get drunk enough to either slip or just make that decision."

Five months before, Jennings had gone to the medical center at Ft. Carson, where a staff member typed up his symptoms: "Crying spells... hopelessness... worthlessness." Jennings says that when the sergeants who ran his platoon found out he was having a breakdown and taking drugs, they started to haze him. He decided to attempt suicide when they said that they would eject him from the Army.

"You know, there were many times I've told my wife – in just a state of panic, and just being so upset – that I really wished I had just died over there [in Iraq]," he said. "Cause if you just die over there, everyone writes you off as a hero."(p. 1)

While Jennings was diagnosed with PTSD in May of 2005, Zwerdling reports in his article that Army records indicated that Jennings was being discharged because of drug use and missed formations. Zwerdling contends that Jennings story is not unique, and suggests that the army repeatedly cites soldiers seeking mental-health help for misconduct, with some soldiers' records indicating a dishonorable discharge. This is a serious accusation considering that soldiers denoted as such are extremely limited in their acquisition of future medical and mental health care services through the VA.

A recent report conducted by the American Psychological Association (APA) and the Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, supports Jennings story regarding lack of available mental health services (2007). After examining several studies and surveys of military personnel over the past four years, the task force determined there were significant barriers to mental health care among U.S. military members due to shortage of providers, reduced access to care and the stigma of seeking health care services. The report cites a 40 percent vacancy rate in active duty psychologists in the Army and Navy, which has created increased work load among remaining mental health personnel, and an ensuing high attrition rate. Clinical social work and psychiatry are also experiencing shortages. One-third of Army mental health personnel have reported “high burnout,” 27 percent have reported “low motivation for their work,” 22 percent have reported “low morale,” and 15 percent have indicated that these problems are “impairing their ability to provide care to their patients” (p. 42).

Long waiting lists, limited clinic hours, and breakdowns in the referral process are cited as impediments for soldiers and their families trying to access mental health services, with particular concern emanating around National Guard and Reserve personnel who often live a long way from military bases where support is centered. The task force also disputed military claims that stigma associated with mental health care services has declined among OIF soldiers. The report states that more than 30 percent of all soldiers meet the criteria for a mental disorder, but only 23 to 40 percent of these men and women seek help partially due to concerns about stigma and negative attitudes within

the military surrounding mental health care treatment. Of the 30 percent of military personnel cited as needing mental health care services, the report notes that all 30 percent personally identify some concerns regarding their symptoms *before* reintegration.

Due to the above noted reports from Harvard and the APA, as well as ongoing media attention detailing lack of services available for reintegrating OEF and OIF veterans, the military health care system came under increased fire during March 2007. Reports of mice and moldy plaster at Walter Reed Army Medical Center in Washington, DC has resulted in the attrition of several individuals associated with the facility including the U.S. Army General in charge of the hospital, George Weightman, and U.S. Army Secretary, Francis J. Harvey. The VA is also undergoing substantial scrutiny and criticism. As opposed to Walter Reed, which primarily treats *active-duty* personnel, the VA focuses on the needs of *veterans* from all branches of the U.S. military as well as members of the National Guard. While the VA insists that it has done everything in its power to provide consistent, high quality mental health care for all veterans seeking treatment, critics claim that the system is overloaded with cases and understaffed to meet demands.

These are serious claims considering the potential influx of soldiers seeking treatment over the next several years. Extrapolating statistics already reported in Chapter III of this thesis, at present time the VA is providing PTSD treatment for over 179,000 Vietnam veterans – more than five percent of the total force deployed to Southeast Asia – *over thirty years after the conflict ended*. Sixty years after the Korean War the VA still provides PTSD care for approximately 11,000 Korean War veterans, and 17 years after

the first Gulf War the VA provides treatment for approximately 19,000 Persian Gulf veterans for PTSD related symptoms; three percent of the overall force deployed to the Gulf. VA records show that nearly 19,000 OEF and OIF veterans were treated for PTSD between 2002 and 2005 at VA facilities, approximately one percent of the total 1.4 million who have served to date. If that percentage were to increase to between three and five percent – consistent with ongoing PTSD treatment for Gulf War and Vietnam War veterans – the VA will be looking at a minimal future client load of somewhere between 42,000 and 70,000 veterans. This is a low estimate considering these comparative percentages from Vietnam (five percent) and the Persian Gulf (three percent) are based on working cases. They do not include veterans who may have accessed the system over the years but whose cases are no longer active or those who chose to pursue outside assistance because of issues relating to stigma.

All the more daunting, if statistics were applied from recent research (Figley, 2006; Hoge et al., 2006; Bilmes, 2007; MHAT-III) which places the number of OIF and OEF veterans closer to 30 percent in need and/or seeking mental health services, we are looking at closer to 420,000 soldiers who at sometime in their lives will suffer functional impairment due to, or exacerbated by, combat-related issues. Current military stop-loss policies, and continuous re-deployment practices, are creating additional stressors which may ultimately increase projected percentages.

In an attempt to better equip the VA to handle potential increases in needs for mental health services, the Bush administration has proposed more than 80 billion dollars be added to the 2008 budget, of which more than \$36 billion would be allocated to the

Veterans Health Administration, with \$3 billion of this earmarked for mental health treatment services (Office of Management and Budget, 2007). Whether or not the entirety of this budget will pass the House is open to debate as mid-term elections recently brought control of both the House and the Senate back to the Democratic Party and debate is currently raging about the increasing costs of OEF and OIF.

This thesis has illustrated how conflicting political and economic decisions pertaining to international vs. domestic concerns over time can seriously effect available mental health care treatment at home. Funding is finite. As we continue to pour more and more dollars into the overall costs of OEF and OIF, less funding will be available to support national social services which will in turn impact mental health care services. If the APA report is correct in stating a 40 percent vacancy rate exists among Army and Navy psychologists, there is a natural assumption that soldiers upon their return will be forced to seek treatment from civilian mental health care professionals. If this is the case, not only will our veterans be seeking treatment among professionals not versed in the biopsychosocial effects of combat-related trauma, they will also be subject to limited access because of managed care policies developed throughout the latter part of twentieth century.

This thesis has also demonstrated the importance of social climate with response to treatment of mental illness and combat-related trauma. As veterans return from deployment to Iraq and Afghanistan, the way in which they are embraced by the American public is in sharp contrast to what our veterans experienced upon their return from Vietnam. Instead of placing the ills associated with war partly on the backs of our

returning service men and women, as was seen in the late 1960's and early 1970's, increasing American disapproval of the current conflict is aimed at the existing President and his administration. There are a few reasons for this shift. Recent reports have stated that initial findings suggesting Iraq's involvement in the 9-11 attacks were false, and to date no one has been able to locate the weapons of mass destruction which the Iraqi government had been purportedly harboring. This has created distrust among Americans with regards to our true purpose in OEF and OIF. In addition, through media newscasts and written reports, it has come to the attention of the American public that many of our soldiers are going off to fight the war ill equipped for battle, with families having to personally provide their soldiers with flak jackets, radios, and GPS units. Considering that all of the U.S. military soldiers engaged in the global war on terror are volunteers, great sympathy for their plight is heartfelt among most Americans despite well-publicized questionable interrogation incidents at Abu Ghrab and Guantanamo Bay. As research presented within the scope of this paper has established, social support plays an integral role in the development of PTSD, and lack thereof is a contributing factor.

*"I am Changed"*

I usually don't tell people about it, about what I did in Iraq. I was picking up dead bodies. They'd look at me as a victim. I don't want to think of myself as a victim. I want to think of myself as somebody who's actually privileged to have a role in something that's changed the lives of so many people.

I was walking through my dorm one night, and I guess somebody might have dropped something or jumped up or up and down or something on the floor above me, and it was just this loud bang from above and I jumped like – like there was a mortar round hitting a couple feet away from me. Everyone around me just started to laugh and thought that it was a big joke, and I just kind of went with it and laughed along with them, but that's how it is. Whenever there's a loud bang or something, my first thought is, *Oh, this is a gunshot or mortar round*, or something like that.

When I first got back, I felt lucky to...to have a story that no one else does. But then there was also the resentment for me having to bear this whole burden for everyone else back home who, you know, just wants to go to school and get drunk and party. Actually, the toughest thing is trying to pick up girls. Because I thought going in there that it'd be great, because I'm this older guy and everything. But I intimidate a lot of the younger girls who are in the same grade as me. I'm twenty-two, a lot older. And they can't seem to get past the fact that I've been to war. I've never really been able to experience college life.

I am changed. When I'm with my veteran buddies, I'm usually one of the more outgoing people. I do nothing but joke around with them. But when I'm out with my college friends, it's just completely different. I'm more quite, more detached. Girls will say I'm shy, but it's not shy – I mean, you know, I have no problem



talking to girls. I just, it's just, I don't...I can't really relate with these people anymore. I'd say that's the biggest thing for me – it's not that, that I've changed in a negative way...I just can't relate with the average college kid anymore.

People are supportive of the troops as long as it doesn't take any sacrifice from them, and I just get so furious with people sometimes that I ... that I just have to leave the room. And I have a long, long list of people who are on my shit list. When we got back from Iraq, me and my friend Tabor were in the car driving to Dunkin' Donuts or something in the morning, and we were at the stop sign with a car in front of us saying "Freedom Is Not Free," and he just looks at me. He goes, "Can you believe this? 'Freedom's not free,' what has *he* paid?"

Dominick King, 7<sup>th</sup> Marine Regiment, 1<sup>st</sup> Marine Division

Falluja; August, 2004 – March, 2005

(Quoted in Wood, 2006, pp. 228-231)

CHAPTER VII  
SMITH COLLEGE SCHOOL FOR SOCIAL WORK AND COMBAT-RELATED  
TRAUMA

*“In its instruction the school aims to promote self-knowledge and enlargement of personality as well as to increase technical skill. The effort is constantly to give such individual attention as to foster in each student growth in character. A psychological approach to social problems is emphasized in all of its courses.”*

*F. Stuart Chapin, Director of the Smith College School for Social Work, 1918-1921*

Clinical social work has been active in the assessment, diagnosis, and treatment of combat-related trauma since U.S. participation in WWI. Stemming from a need to be of service to the country during war time, the Training School of Psychiatric Social Work at Smith College was first established during the summer of 1918, with the first group of 55 graduates entering the field in March of 1919 (Neilson, 1919). Described as “actuated by the desire to furnish themselves with a knowledge and aptitude which would enable them to help in salvaging the human wreckage of the war,” the students varied in age from young women fresh from college to social workers of middle age seasoned by experience in the field (Neilson, 1918, p. 582).

In an attempt to capture the school’s historical contribution to the field of psychiatric, or clinical, social work as it pertains to combat-related trauma, this chapter will examine how curriculum, theoretical perspective, and endorsement of treatment

paradigms may have influenced students throughout the years in their attempts to work with returning veterans suffering from trauma-related neurosis. Questions addressed will include: How has curriculum evolved over the century to better reflect the needs of returning soldiers suffering from combat-related trauma? What theoretical models have most influenced the school's perspective, and how have those models served to prepare students for trauma treatment interventions? What have we learned? What do we need to implement, if anything, in order to make us more effective in treatment dynamics? As this thesis has readily demonstrated from several perspectives, the transparency of history provides a true understanding of how the phenomenon of trauma treatment has evolved and matured to present day. Let us now examine the role in which the Smith College School for Social Work played.

#### *The Early Years: 1918 – 1930*

While a social work concentration in psychiatry existed in the field prior to Smith's training program, instruction had been limited to a select group of students through the Boston Psychopathic Hospital (Solomon, 1918). The Director of the hospital, psychiatrist E.E. Southard, along with its Chief of Social Service Mary E. Jarrett, saw an urgent need to extend schooling tantamount to America's entrance into WWI and joined forces with Smith College, which was interested in assisting in the war effort by utilizing the resources of the school during the long summer months (Neilson, 1919; Solomon). The National Committee for Mental Hygiene, after reading a paper by Dr. Southard entitled *Mental Hygiene and Social Work: Notes on a Course in Social Psychiatry for Social Workers* (1918), in which the psychiatrist argued the necessity for such training to

take place, embraced the concept and directed the Charity Fund of the Boston Safe Deposit Company to underwrite Mary Jarrett's organization of the war course (Solomon; Southard, 1918). Reflecting on the course's initial conception, W.A. Neilson, President of Smith College at the time, wrote "They attempted to establish a method for the training of psychiatric social workers – a phrase which I confess terrified my constituency until they learned how to spell it" (Neilson, 1919, p. 59).

There are few who would argue that the Training School of Psychiatric Social Work at Smith College in the early years was anything but diagnostic in design. An account of the school's first year is well articulated within Bertha Capon Reynolds' historical analysis *An Uncharted Journey: Fifty Years of Growth in Social Work* (1963). Reynolds writes that mental conditions at the time were classified into eleven major groups, and approach to diagnosis was through exclusion – beginning with the best known disease categories. Through courses on psychiatric method students came to understand that these disease categories also occurred in combat conditions, with "added incidence of fear of annihilation or injury" (p. 58). While shell-shock was viewed as a psychological condition which occurred on the battlefield through the stress of war, Reynolds reflects that "some who broke under the strain of war would sooner or later have broken at home" (p. 58). Reynolds writes that the school was particularly focused on Freudian psychology, and that students were most concerned with the inner workings of patients with a primary focus on therapy "rather than the social accompaniments of the patient's illness" (p. 61). Students quickly came to understand that "psychiatry [was the] key to unlock[ing] all the mysteries of personality in all kinds of circumstances" (p. 58).

With focus on the subconscious, students monitored each other carefully during that first summer. “We saw fears displaced from childhood, jealousy displaced from other persons, hostility disguised as solicitude, desire as fear, and wish as certainty” (p. 59). The significance of Freudian influence, as well as the graduates’ youthful exuberance, can best be demonstrated in a song composed by students during that first summer session of

1918:

THEY GO WILD, SIMPLY WILD, OVER ME

We go wild, simply wild over Freud.

With our psychoanalysis we’re overjoyed.

Our libido knows no fright

We dissect our dreams each night

We’re fresh on repression

Transference our delight.

No dismay we display over sex

And it’s we who are free from complex.

But we know from what you dream

That you are not what you seem

For we’re hip, full of pep, over Freud.

(Bertha C. Reynolds Papers, Sophia Smith Collection, Smith College, Northampton, MA)

While students certainly enjoyed moments of camaraderie, as reflected above, the academics were rigorous and demanding, and attrition during that first summer is well documented:

Of the seventy, some three or four fell out at once, fortunately recognizing that it was no place for them. A few more, it developed, did not have the physical strength. Two or three were found not up to the mark at the examinations. The tests that were applied were as severe as the ordinary academic tests. (Neilson, 1919, p. 62).

Students who persisted were sequestered in college dorms, along with their instructors, with no college activities or distractions, and expectation that they would devote a minimum of eight hours a day to their studies (Neilson, 1919). Instructors were amazed with the student's resilience and enthusiasm for their subject matter and their ability to quickly synthesize lessons learned:

Besides the war fervor and the habitual zeal of young women in learning new things, there was a certain tone of maturity of point of view on the part of these social work students that surprised a little those of us who were familiar with the atmosphere of social work conferences in the past...I am bound to say that with what I know concerning psychiatric instruction for medical students, these women got a fuller account of the general aspects of mental diseases than medical students in their third year ordinarily get in medical schools.

(Southard, 1918, pp. 584, 585)

The length of the entire course the first year was eight months in length and separated the didactic work from practical application with eight weeks of academia occurring at Smith College from July 8 to August 31, followed by six months of fieldwork carried out in clinics and hospitals located in Baltimore, Boston, Cincinnati,

New York and Philadelphia from September of 1918 to March of 1919 (Solomon, 1918). Academics included courses on sociology, methods of case work, psychology, methods of investigation and record, laboratory work on mental tests, and social psychiatry, with secondary emphasis on military usage, hygiene, writing of records, and occupational therapy (Neilson, 1918; Solomon). The course work reflected a diagnostic approach throughout, particularly with regards to scientific method and individual case work. Courses were taught by Smith College professors, physicians, and eminent psychiatrists with clinics held at the Northampton State Hospital. The list of individuals who lectured during the first summer is very impressive, including both Dr. Southard and Dr. Josephine Foster of the Boston Psychiatric Hospital; Dr. Adolf Meyer of Johns Hopkins Hospital; Dr. A. A. Brill from New York; Dr. Ray Lyman Wilbur, President of Stanford University; and Miss Jessie Taft, Director of Social Service for the Committee on Mental Hygiene (Spaulding, 1918).

The training program's curriculum duly reflected the significance of the war and the primary objective of its formation which was to "prepare social workers to assist in the rehabilitation, individual and social, of soldiers suffering from nervous and mental diseases, including war-neuroses and the so-called shell-shock" (Solomon, 1918, p. 4). The first course in social psychiatry studied only those mental conditions which were related to war neuroses and psychoses. It consisted of ten and a half hours per week of lectures including two two-hour clinics at the Northampton State Hospital and five additional lectures lasting approximately an hour and half each (Spaulding, 1918).

Experts on war neuroses from around the globe lectured on the subject that first summer at Smith, including Captain A.E. Bott and Captain C.B. Farrar from Canada (Spaulding).

When the students graduated in March of 1919 the armistice had been signed and the First World War had come to an end, but their training was not completed in vain. The reintegration of soldiers began, and psychiatric social workers were in much demand from local and state facilities and later federal veterans' hospitals as they began to form (Ehrenreich, 1985). Throughout the twenties the Veteran's Bureau became the largest employer of psychiatric social workers in the U.S. (Ehrenreich). Whether destined for civil or military work, Mary Jarrett exclaimed in 1918 that upon graduation students would be expected to know how to "secure social histories required for medical diagnosis; assist in the reeducation of patients in hospital if pressure of work upon the physicians makes such lay assistance desirable; and undertake the social readjustment of discharged patients" (Jarrett, 1918, p. 594). It was also hoped that through their studies, which included an autobiographical case history, students would develop empathy and tolerance for those suffering from mental illness and a greater understanding of abnormal behavior in general (Spaulding, 1918). We return to Bertha Capon Reynolds (1963) as she recaps her experiences of that first summer:

The revolutionary content of what we learned in that summer at Smith stayed with us, if the classifications did not. We thought in terms of patients as individuals. We social workers were most concerned, as the psychiatrists were, with what went on inside the patient. It was also our job to know what, in his family, community life, and war service, had contributed to his illness. We were eager to



help get the patient back to normal living, but to do so mainly by restoring him to himself, when, as a whole person, we liked to believe that he could cope with his life conditions in his own way.

Our concentration on therapy, rather than on the social accompaniments of the patient's illness, was brought out when the class was eagerly awaiting the assignments for six months of field practice. When the announcement was finally made in August, those who could not be accommodated in army hospitals or Red Cross units, but were sent to the New York Charity Organization Society, were bitterly disappointed. "We did not come here to learn social work but psychotherapy," they said. (p. 61)

Ms. Reynolds proceeded to intern at the Danvers State Hospital where she survived the influenza epidemic that swept across the U.S.; learned a focused method of progress note taking with patients (which she would later teach at Smith); and utilized Freudian theory at every opportunity (Reynolds, 1963). She spent four years at Danvers, the last in which she supervised a student from the school, which had since been renamed the Smith College School for Social Work. The graduate program now consisted of 14 months of study, including two summers of academia in Northampton and a nine-month practicum (Chapin, 1921). As the program grew, students were supervised more methodically during their internships and lecture work began to be interspersed throughout (Neilson, 1919). The school had decided, prior to the graduation of its first class, that a lengthier and more complete training program could be offered now that the

threat of war had diminished. The school also decided to incorporate another level of learning to the curriculum and practicum – that of the thesis (Chapin, 1921).

By 1921 students graduating from the school had prepared and completed a thesis based on practical experience and study, with the purpose of additional training in the “application of scientific method to the study of social problems and social situations” in partial fulfillment of the requirements for the degree of Master of Social Science (Chapin, 1921, p. 665). Influenced by a strong desire to be recognized as a profession which gathered relative data by scientific, or organized, means, diagnostic schools of social work not only favored psychoanalysis, which explored the “irrational” scientifically, they created curriculum which was distinctively medical in design and closely aligned with psychiatry (Ehrenreich, 1985).

With regards to the Smith graduate program, considering the very structure of the school was determined by Mary Jarrett and Dr. E. E. Southard, both affiliated with the Boston Psychiatric Hospital, this alignment should be of little surprise. It must also be remembered that the majority of social workers during the early 1900’s were female and very much considered a low-status social group, despite the efforts of individuals such as Jane Addams and Mary Richmond. In addition, social work itself was considered to be a social past-time for middle and upper-class women who, while admirable in their concentrated efforts to assist the poor, were hardly considered “professional.” Until 1920 anyone could be a social worker, should they desire, as the field had no professional qualifications; hence the strong determination to undergo professionalism and quickly established standards among those with advanced degrees (Ehrenreich).

When the thesis was added to the curriculum in 1920, it was an opportunity for the school to further distinguish itself in academic rigor and standards. Editor of the first edition of *Smith College Studies in Social Work* (1930), Helen Leland Witmer writes:

The primary function of the Smith College School for Social Work is to educate social workers. But because a social worker cannot be solely an artist and still be a good artist, the School adds a touch of science to her training – by means of a thesis. The chief aim of the thesis is thus the development of a point of view. The School does not expect that social scientists will be created through the magic of a single thesis. But it does hope that the student social worker will catch a glimpse of the joys and the perplexities that arise in the attempt to wring a bit of scientific truth from the social data, and that she will carry over into her work with individual cases some of the critical spirit and the interest in the larger group that characterizes the scientist. (P. 3)

A wonderful example citing scientific approach in determining environmental influences on diagnosis, as well as the early role of Smith psychiatric social workers, and the impact of several prominent movements discussed in prior chapters of this thesis, can be found in graduate Nancy Hegner's thesis entitled *Environment as an Etiological Factor in Psychoneurosis* (1921):

The psychiatrist realizes that he does not understand social conditions as does the social worker, and even if he did he does not have time to follow up his patients, to see that each one is carrying out the directions for his treatment and is adjusting in his work, his community, and his home.

Before a worker is able to carry on any treatment she first makes a thorough investigation of [the] patient's life, including family, educational, occupational, social history and home and present condition of [the] patient. These facts are put in complete form, analyzed and used by the physician to help him make a diagnosis and recommendation for treatment. The social worker also analyzes and makes a social diagnosis. Her knowledge of these facts added to the psychiatrist's advice gives [the] worker a broad basis for social adjustment of their patient. A plan of treatment is then decided upon whereby all the elements of the individual's life are so organized as to affect the best adaptation to his environment that is possible. (pp. 4, 26)

Understanding of how an individual's personality is shaped by environment – a necessity when compiling a “social diagnosis” – was very much the construct of the mental hygiene movement as referred to in Chapter IV of this thesis. Also discussed in Chapter IV were the influences of eugenics and social Darwinism in the early 20<sup>th</sup> century – both of which can be seen in the first few sources listed in Ms. Hegner's “causative factors in psychoneurosis” on page three of her thesis. She cites heredity, constitutional defect, predisposition, mental fatigue, emotional fatigue, fear, gas (during WWI), injury, disease, and compensation all as possible decisive factors in the development of psychoneurosis. Further, Ms. Hegner reflects a marked Freudian perspective with regards to etiology of war neurosis:

There is found in war neurosis a great simplicity of the psychic mechanism operating to produce symptoms and appearances of severe neuroses in people

who are apparently normal before their exposure to the hardships of war. It is learned that each individual has a pugnacious instinct which through ages of civilization has been repressed, its only outlet being in physical exertion and athletic contest. The origin of the repression then is found in the gregarious or herd instinct which increases through civilization. These two instincts are in constant conflict during warfare. Also the instinct of self-preservation is in conflict with the individual's sense of duty or with the fear of being called a coward. (p. 6)

In an address to the Austrian War Ministry following WWI, Freud had stated: The immediate cause of all war neuroses was a soldier's unconscious inclination to remove himself from the aspects of military service that are dangerous or offensive to his feelings. Fears for his own life, resistance to the command to kill others, revolt against the total suppression of one's personality by superiors were the most important emotional sources that nourished the inclination to shun war. (Holden, 1998, p. 30).

Freud's position on etiology, along with his theoretical concepts of "instincts" and "repression," obviously served to influence Ms. Hegner's understanding of war neuroses, but she ends her thesis with a discussion pertaining to the importance of the social worker's attitude, and the necessity of keeping perspective in order to always appear professional – supporting concerns of the day to maintain professional integrity: Much of the treatment of these patients depends upon the attitude of the social worker. The physician advises the social treatment but as he himself is unable to

carry this out he relies upon the social worker. If the social worker deals in maudlin sentimentality in regard to the soldier patient, she is not only liable to bring great harm upon the patient but the psychiatrist's reaction to her feeling may be one of sternness to the soldier and disgust for social work. Understanding sympathy is useful and helpful but misdirected sympathy is harmful. A social worker then must always remain in full control. (p. 26)

#### *1930's - 1940's*

In the early 1920's the Smith College Training School for Social Work had tried to introduce degrees in both Medical Social Work and Community Service, but both courses were discontinued by the latter half of the decade. Psychiatric social work had become the dominant educational model throughout the North East, with Smith's curriculum continuing to focus on "the adjustment of personality to environment and to other personalities" (Kimball, 1930, p. 2). The role of the psychiatric social worker had evolved allowing for further opportunities for practice of theoretical skills but continued to focus on the individual:

She [psychiatric social worker] may change unfavorable environmental conditions or, better still, get the people concerned to change them; she may interpret by spoken word or, better, by giving an opportunity for new experience. She may let people try out on her their distorted emotional patterns and use her skill to correct them. Whatever the form of therapy, it is because a maladjusted individual usually means also an environmental situation gone wrong that the trained psychiatric social worker has a role in therapy that no one else can fulfill.

Bertha Capon Reynolds, 1963, p. 111

In examining writings from this period it is obvious that psychiatric case work certainly contained a holistic component, but professional emphasis was placed on the social workers capabilities and knowledge as a change agent vs. a patient's individual determination or the idea of empowerment. The diagnostic school of social work believed it was the responsibility of the psychiatric social worker to look beyond the needs presented by the patient; understand the causative factors contributing to their illness; and determine treatment goals beyond those which the patient may articulate (Ehrenreich, 1985). This paternal perspective was supported by the medical model, whereby patients were categorized into specific categories that insinuated scientific report (Weckowicz, 1984). Two changes would occur over the 1930's which would impact this perspective: the Great Depression and the Functional approach to casework.

With the onslaught of the Great Depression, political convictions that welfare issues should not be the concern of the Federal government forced private agencies such as the American Red Cross to address the needs of the poor alone (Jansson, 2005). Convinced that poverty was a result of characterological deviations, not unlike some perceptions of mental illness, several social, political, and religious entities ignored cries for help by the unemployed masses resulting in the entrenchment of service agencies throughout the U.S. that had previously relied on state and federal funding. These psychiatric agencies and clinics had previously served as field placements for Smith graduate students, and the school suddenly found itself in a dilemma – how were they

going to continue offering students high level practicum's in psychiatric social work in agencies which had become overburdened and disorganized?

The Smith College School decided the best answer to this challenge would be to lengthen the graduate course from three sessions to five – two winter internships and three summers of academics – which began in the early 1930's (Reynolds, 1963). In order to ensure that students would continue to exhibit advanced expertise for which the school had gained a reputation, it was the belief among school officials that two internships would allow for better training overall and make up for any inconsistencies due to agency upheavals. It was also decided that first year interns would learn best in “settings where the administrative elements were relatively large, the procedures definite, and the discipline of facts compelling” (such as state hospitals) (Reynolds). As public assistance agencies gained stability and became functional again first year interns were re-assigned (Reynolds). Second year interns, it was decided, would be better equipped to work in family agencies (which gave up their relief function after the depression) and were skilled enough to deal with extremely complicated emotional problems (Reynolds).

While the impact of the Great Depression had forced the school to re-consider its field training program, it also created a question as to the relativity of psychiatric case work as it related to the needs of the community at large. The Depression created dependents of millions of “normal” families, and their troubles could not realistically be addressed in terms of psychosexual maladjustment (Reynolds, 1963). Most psychiatric social workers took on administrative roles during the depression, and oversaw the dispersing of aid such as Temporary Emergency Relief funds (Reynolds). This was a far



cry from administering primarily to the emotional needs of individuals, and many psychiatric social workers found the transition difficult and not “real casework;” resisting the need to take community action on behalf of their clients. Looking more like the case work of the early 1900’s, which had focused not only on the symptoms of poverty but in finding causal relationships, a need to be more “professionally conscious” was permeating the field. Graduate Bertha Capon Reynolds, who was Director of the Smith College School for Social Work at the time writes “it is not conceivable that [social casework] can allow itself to be used by communities to cover exploitation or to distribute the gifts of philanthropy while the social order is itself destroying life by its injustices” (1963, p. 141). Just as many psychiatric social workers were becoming discontent with the paternalistic model of treatment, Virginia Robinson published *A Changing Psychology in Social Work* (1930) (Ehrenreich, 1985).

Ms. Robinson was the longtime associate director of the Pennsylvania School of Social Work who believed that the mechanistic and deterministic view of man, as expressed in Freudian theory, was flawed (Smalley, 1970). Influenced by the works of Otto Rank, a disciple of Freud who served on the faculty of the Pennsylvania School, Robinson believed in human “will” as the controlling and organizing force, and that individual transformation came about through the experience of the client in their relationship with the social worker within the agency setting, and in the way in which they used agency functions (Ehrenreich, 1985; Smalley). Social workers, from Robinson’s perspective, should not be the central figure in the client-social worker relationship; rather the relationship should allow for the client to direct change and “come

to know and test himself or herself, his or her limits and strengths. Even the administration for a simple agency function, then, became individual therapy through a treatment relationship” (Ehrenreich, p. 125).

The functional approach to social work continued to develop through the works of Robinson, Jessie Taft and Ruth Smalley, with the approach focusing on the here and now, and short-term treatment; stressing a time-limited strategy concentrating on issues coming from within the function of the agency (Ehrenreich, 1985; Smalley, 1970). This application was counter-intuitive to the diagnostic school which viewed treatment as long-term with focus on personality transformation. The functional school de-emphasized diagnostic inquiry, history taking, and the setting of treatment goals, believing that these would emerge naturally through the course of the client-social work relationship (Ehrenreich). The diagnostic approach used all of these concepts in great depth in order to better understand the person-in-environment and treat them in their entirety. Unconscious motives and resolution of inner conflicts were ignored completely as functionalists felt these concepts simply allowed for manipulation on behalf of the psychiatric social worker to decide necessary treatment objectives in tune with social norms; viewing the client as a “patient” in need of healing (Ehrenreich).

While the functionalist approach appeared extremely practical throughout the Great Depression, when psychiatric social workers spent much of their time administering to social welfare needs, in the aftermath a chasm developed between social workers who wished to return to practicing “pure therapy,” and those who believed “the essence of social work was contained in the functioning of social agencies” (Ehrenreich,

1985, p.131). Accusations from the functional school that social work was not scientific in the usual sense of the word served to further inflame the diagnostics who responded through their spokeswoman Gordon Hamilton who stated “the base of social work is potentially scientific; that the social sciences allied with the physical sciences must increasingly throw light on social needs and social improvement; that the organic and psychogenetic theory of personality is fundamental” (Ehrenreich, p. 131). Furthermore, diagnostics argued, reliance on agencies which, in turn, relied on state and federal funding in order to survive, as well as government social policy decisions, was a grave error. Social workers in such positions were nothing more than employees who functioned as bureaucrats for the agencies overall goals (Ehrenreich).

The two schools of thought continued to exchange verbal blows for more than a decade, with graduates of the functional schools (i.e., the University of Pennsylvania and the University of South Carolina) finding it difficult to obtain employment in agencies depicted as diagnostic, and vice versa (Ehrenreich, 1985). But many schools and individuals gave some credence to Robinson’s approach, including Smith College School of Social Work which continued to place students in Philadelphia agencies, and by all reports found “its whole curriculum enriched thereby” (Reynolds, 1963). Bertha Capon Reynolds (1963) writes:

My own reaction was one of wonder and deep delight to find expressed so much that I had come to believe. While I could not follow entirely the theoretical background in the works of Otto Rank and the Gestalt psychologists, it seemed to me that the relationships of human beings to each other contained the dynamics of

living and that in these could be sought the source of the personal influence which Miss Richmond had found to be the essential core of case treatment. By 1931 social casework had gone far toward becoming professional, but the secret of helpful work with people was still a person-to-person relationship. That this was not something to be ashamed of – something infected with the hocus-pocus of magic – but a reality to understand scientifically and to use responsibly was a thrilling idea when it first made its appearance in our professional literature.

My review of Miss Robinson's book in *The Family* welcomed a diminished reliance on detailed histories as guide to treatment, and saw in the relationship of client to caseworker the best guarantee that what history was brought by the client would be soundly used, because it would be important to him and relevant to his problems. The client was moved into the central position in the picture which had been occupied by a wise social worker bearing gifts. The challenge was to learn to understand and use the relationship so that the client would be strengthened to build up his own resources. (pp. 120, 121)

Ms. Reynolds believed that Robinson's approach encouraged psychiatric social workers to become more conscious of the client as a person with a right to accept or reject help and use it in any way which they felt would be most beneficial (Reynolds, 1963). Reynolds also appreciated Robinson's declaration that a client's behavior at the agency could be equated as a "sample situation," whereby behaviors towards the social

worker could be construed as originating from interpersonal patterns developed with their parents (Reynolds, p. 122). Both of these concepts are widely practiced today. Respect for the client as a whole person prior to their entrance into the therapeutic relationship guarantees a client's self determination and empowerment. In addition, through the understanding that behavioral patterns occurring within the therapeutic relationship have manifested themselves developmentally throughout the clients life, the clinical social worker begins "therapy" from the moment the client appears as opposed to waiting until assessment, etc. has been completed. Functionalists held that assessment was a natural progression within the therapeutic relationship, and many clinical social workers have come to believe that for numerous clients this assessment process may be all that is needed for personal growth and healing, even if it transpires over relatively few sessions.

The Great Depression and the functional approach to case work allowed Smith, and other diagnostic schools, to further examine their purpose and function during a period wherein focus on the individual was set aside in favor of community action. While the Great Depression eventually came to an end, and the concepts of functionalism were absorbed into various other approaches, their influences on Smith curriculum between 1930 and 1945 is apparent.

In 1930 the curriculum emphasized course work in psychology, psychiatry and social case work, with a few classes on government and public health (which included the study of eugenics and heredity). By 1935, after the school split into five sessions, psychiatry was moved to the second summer (significant in itself), and the public health course dropped the discussion of heredity and eugenics. Within the curriculum Bertha

Capon Reynolds offered a special seminar entitled *Social Case Work in a Changing Society* which addressed, among other things, client needs with respect to ongoing social turmoil.

By 1940 the curriculum demonstrates further efforts to recognize community issues within the academic structure, and new courses entitled *Community Organization; Community Organization and Social Case Work; The Social Worker and the Labor Problem*; and the *Appreciation of Culture in Case Work* made an appearance (Courses of Instruction, 1939-40, pp. 17, 18). Finally, in 1944, fourteen years after Robinsons' book was first published, the Smith curriculum offered an elective course entitled *Psychiatric Orientation*, with the description reading "A comparison between behaviorism, Gestalt psychology, and psychoanalysis as points of view which contribute to a psychiatric approach to human behavior. A comparison between descriptive psychiatry, psychobiology, Jungian, Rankian, and Freudian psychology" (Courses of Instruction, 1944-1945, p. 27).

### WWII

While the 1944-1945 curriculums of the Smith College School for Social Work certainly depict changing theoretical perspectives, one topic seemingly absent is specific subject matter pertaining to the treatment of combat-related trauma. Whereas psychiatric curriculum from Smith's first graduate class focused primarily on neuroses associated with the combat trauma of WWI (Spaulding, 1918), nowhere in the curriculum during WWII can such obvious inferences be made. The only class referring to the war was *Law and Social Work* which examined, among other things, the "Soldiers' and Sailors' Relief

Act as far as its application to social work problems” (Courses of Instruction, 1944-1945, p. 28).

Upon a closer examination, however, several significant connections between trauma treatment during WWII and Smith curriculum become apparent. The first such connection pertains to preventative testing. Initially, the primary role of American psychiatry in WWII was to focus on prevention, as compared to treatment, through “the detection and separation at the earliest possible time of bad military risks, from a psychiatric point of view, [those] who had somehow slipped past the draft and induction-station medical examiners” (Deutsch, 1944, p. 420). In developing this objective a double screening process was established in which mental tests were initiated; the significance of such testing with regards to case work was discussed within the class entitled *Mental Tests* in the Smith curriculum of the early 1940’s. Experience in testing techniques was a very employable skill, as graduates from the school found employment in war industry personnel departments as well as induction centers (Smith College School for Social Work, 2007). Bertha Capon Reynolds was one such student who became active with the National Maritime Union and worked with Merchant Seamen and their families throughout the war years (Smith College School for Social Work, 2007).

Another link between treatment interventions offered in combat-related trauma cases during WWII and Smith curriculum includes the subject of Group Work. Nothing was considered worse for morale than the evacuation of soldiers from front lines for psychiatric reasons, thus much effort was placed on the debriefing of soldiers following the day’s operations. Introduced during WWII by General S. L. Marshall, group

debriefing was utilized to help troops develop a narrative of the days events, and was believed to have significant emotional benefits (Bisson, McFarlane, & Rose, 2000).

Group debriefing was the first form of group therapy as we know it today, and in their 20-year follow-up study examining persistent stress reaction after combat in WWII combat veterans, Archibald and Tuddenham (1965) write “Our hypothesis is simple: combat was experienced in a group setting and can best be abreacted in one” (p. 480). Within the 1944-1945 curriculums, Smith introduced the course entitled *Group Work*, which was described as:

A basic course designed to give an understanding of the social implications and meaning of social process in group interaction as it is pertinent to professional activities in social work; also to give some understanding of the concepts and methods which underlie any conscious effort to give purpose and direction to the group process in the development of the individual and the group.

(Courses of Instruction, p. 22).

A final connection that must be addressed, which highlights Smith’s pioneer spirit with respect to academia during this timeframe, is the study of psychosomatic medicine. One of the most significant treatment outcomes of WWII was the recognition given to the psychiatric component in the development of certain somatic complaints (Deutsch, 1944). Peptic ulcers, one of the most serious illnesses in the armed forces, were approached during WWII from a functional, as opposed to organic, perspective (Deutsch). This significant change was associated with several studies examining the causation of gastrointestinal disorders, cardiac syndromes, and dyspepsia (Jones & Wessely, 2005).



Recognizing the emerging importance of psychosomatic medicine, and to better prepare psychiatric social workers for the diagnosis and treatment of such disorders in returning soldiers, the Smith College School for Social Work in 1944 offered the course *Psychosomatic Medicine*, described in the curriculum as “lectures on the emotions and bodily changes, including the management of psychosomatic problems from the point of view of psychiatric and medical social service teamwork” (Courses of Instruction, 1944-1945, p. 26).

In addition to academic support offered to students working with individuals suffering from combat-related trauma, the program itself was shortened during WWII to a 15-month instead of a 24-month curriculum so as to accommodate students and instructors, and a special training institute was set up on site for supervisors in U.S. Army and Navy hospitals (Smith College School for Social Work, 2007). Scholarships for students from The American Red Cross and Veteran Administration hospitals were also offered, along with a commitment for one year employment (Courses of Instruction, 1944-1945, p. 21; 1949-1950, p.18). World War II resulted in the continued growth of the VA health care system as well as the introduction of the GI Bill, which included educational assistance to veterans. Because psychiatrists were thought to be in short supply, the GI Bill had approved medical and analytic training for returning veterans, and by 1951 a total of 1,800 residencies had opened up across the country, up from 400 positions before the war (Crammer, 1999; Jones, 2000).

Psychiatric social workers were also in short supply, and on July 28<sup>th</sup>, 1949 Smith College began an advanced program of academic study beyond the masters program

which included two ten-week summers of academics and one field practicum. For the first time Smith academics were opened to men as well as women, with students “between the ages of twenty-five and forty who show outstanding aptitude and achievement” given preferential treatment in the admissions process (Courses of Instruction, 1949-1950, p. 20). Entitled the “Third-Year Certificate,” the program eventually led to the degree Doctor of Social Work (D.S.W) in the mid-1960’s which required three ten-week periods of academic work on campus, and a formal prearranged sequence of courses during two winter practice periods (Courses of Instruction, 1964-1965, p. 23). The first practice period focused on clinical work; the second on the completion of the dissertation.

### *The Korean War*

At the start of the Korean conflict psychiatrists in the U.S. military still believed that screening could be a reliable means of prevention if the appropriate variables were measured. While the screening of psychological vulnerabilities during WWII had been considered a wretched failure, as demonstrated by the high numbers of soldiers needing treatment for neuropsychiatric disorders, Jones and Wessely (2005) noted that screening efforts during the Korean conflict focused on the measuring of intelligence, which was considered fairly reliable. In understanding the changing focus surrounding such measures, the class previously entitled *Mental Tests* in the early 1940’s at the Smith College School for Social Work was now entitled *Implications of Psychological Testing* within the 1949-1950 curriculums, indicating continued alignment with the medical

model of practice, but suggesting concern for possible consequences of such testing as well.

Additional changes reflecting the needs of Smith graduate students treating trauma during the Korean War can be found within the 1950 curriculum. Course number 591, entitled *International Casework*, made its first appearance in 1950, and examined “problems, principles, and methods involved in the extension of casework through internationally coordinated services” (Courses of Instruction, 1949-1950, p. 27). Stemming from “ties established by members of [U.S.] armed forces in foreign countries,” (p. 27) among other factors, the course trained psychiatric social workers in methods of international social case work which would have been extremely beneficial to U.S. service men and women seeking assistance from within foreign cultures. Delayed reintegration of U.S. soldiers serving in Korea after 1953, following extensive exposure to Korean culture, would surely have created a need for knowledge gleaned from such a course. In addition, the Second World War had created significant devastation – political, economic, and social – necessitating the work of trained psychiatric social workers to assist with displaced populations and people seeking to recover from the trauma of war both overseas and on the home front.

The sheer numbers of soldiers returning from Korea, who were suffering from combat-related trauma, combined with a lack of qualified therapists to treat them, necessitated briefer, more effective psychotherapies that were less costly, less time consuming, and had the ability to reach greater numbers (Frank, 2000). Such conditions created a high demand for psychiatric social workers and slowly the development of time

limited dynamic psychotherapies, as well as cognitive-behavioral and group therapies, evolved within academic institutions. These trends were supported and hastened by advancements in psychopharmacology and neuroscience where the attentions of psychiatrists were primarily focused (Frank).

Throughout the 1950's and 1960's Smith graduate school curriculum indicates little academic application pertaining to the study of briefer methods of therapy, instead choosing to shift from an earlier psychoanalytic focus on repressed unconscious material to an emphasis on ego functions and personality development. The course *Ego Psychology* was first offered during the 1949-1950 academic term and was geared towards those in the advanced class who wished to further expand their knowledge of "psychoanalytic concepts as applied to the understanding of personality problems"(Courses of Instruction,1949-1950, p. 21). In order to drive home the theoretical perspective, case material on children and adults was utilized with particular focus on ego functions. Regular masters students were exposed to the hypothesis of ego defense mechanisms in the class *Dynamics of Human Behavior I*, and the concepts behind the psychosocial stages of development were discussed by the author himself when Erik Erikson gave the keynote address at the annual supervisors' conference in 1950 (Smith College School for Social Work, 2007). By 1964 the impact of Ego psychology was well established within the Smith graduate school curriculum.

One only needs to read the course description for the 1964 version of *Dynamics of Human Behavior I*, which included study of the "manifestations of instinctual and ego forces in relation to adult character formation and the individual's adaptation to his

environment [as] described in psychodynamic terms,” to comprehend the influence of writers such as Heinz Hartman, Melanie Klein, Anna Freud, and Erik Erikson on Smith curriculum (Courses of Instruction, 1964-1965, p. 37). Additional Smith courses in advanced case work, which applied treatment approaches as they related to strengthening ego functioning, assisted the field in replacing earlier psychiatric social work focus on repressed unconscious material with more focus on the here and now as it applied within the therapeutic relationship (Ehrenreich, 1985).

It could be argued that focus on the here and now somewhat supported a move towards briefer therapeutic interventions, but for the most part during these years the Smith College school for Social Work appeared to look upon the field experience vs. classroom academics to better prepare students in less costly and less time consuming treatment interventions for soldier with combat-related trauma. Similar inferences might be made with regards to Smith's early focus on psychopharmacological interventions. Dr. Glen Gabbard states in *The Evolving Role of the Psychiatrist from the Perspective of Psychotherapy* that while psychotherapy was still very much at the forefront of psychiatry in the 1950's, the field of psychiatry had taken the lead in neuroscience and psychopharmacology developments and was working to realign the specialty with mainstream medicine (2000). Events which encouraged this process included the identification of the neurotransmitter dopamine which had helped to produce the first maps of monoamine neurotransmitter pathways in the brain (Healy, 1999), as well as the discovery that neuroleptics in the treatment of schizophrenia could modify mental activity previously disturbed by psychotic processes (Olie & Loo, 1999).

Discovering a drug which had the ability to control the symptoms and signs of psychosis was a major medical advance, and it was quickly followed by the discovery of antidepressants, tranquilizers, and benzodiazepines (Olie & Loo, 1999). Surprisingly, the Smith graduate school refrained from the academic inclusion of psychopharmacological interventions as they effected current understanding of treatment until the late 1960's when such material was finally incorporated into course 351, *Personality Development IV*, which discussed psychopharmacology as it related to emotional illness (Courses of Instruction, 1969-1970, p. 29).

Although the Smith College School for Social Work does not appear to have made significant curriculum adjustments in response to known methods of treatment of soldiers suffering from combat-treated trauma during and after the Korean War, this is understandable given the educational goals of the school which included the placement of graduate students into a variety of public and private agencies, as well as supervisory and administrative positions. Students were not just treating combat-related trauma. Perhaps in response to critics who felt that academic focus should be more reflective of the times, in 1949 the school stated "The educational plan of the Smith College School for Social Work is based on the premise that there is a basic core of knowledge and skill in social work which transcends the specializations;" a statement reflective in current educational documentation which still considers clinical social work to be a specialization in and of itself (Courses of Instruction, 1949-1950, p. 15). Interesting to note: between 1950 and 1959 fourteen theses discussing the mental health needs and interventions with veterans were published in the *Smith College Studies in Social Work* (Smith College School For

Social Work, 2007) – indicating both the school’s and the student’s continued commitment in mental health issues of veterans despite what appears to be a lapse in the prospectus.

### *The Vietnam War*

Social workers throughout the 1960’s and 1970’s found themselves advocating for a variety of oppressed individuals and groups involved in the Vietnam war, the civil rights movement, the war on poverty, mental health care accessibility, and sexual discrimination, making this era one of the most tumultuous periods for the field of social work. Once again, as in the 1930’s, psychiatric social workers practicing from a psychodynamic perspective were attacked for their seeming lack of advocacy in the face of social change and social reform (Ehrenreich, 1985). At the Smith College School for Social Work Dean Howard Parad was appointed - a man who had begun his social work career by serving as a psychiatric social worker during WWII (Smith College School for Social Work, 2007).

While one may have naturally concluded that Dean Parad’s affiliation with the military would have initiated a strong commitment to the mental health care treatment of returning veterans, other considerations were at play. A combination of the civil rights movement along with VA decreases in funding resulted in a momentary tapering-off of the Smith-VA relationship and a renewed focus on the issue of multicultural practice (Smith College School for Social Work, 2007). Continued affiliation with the VA Court Clinic in Boston continued, however, and other VA sites which were concentrating on the etiology, pathology, and treatment of combat-related trauma participated in the Smith

graduate internship program (Smith College School for Social Work, 2007). The VA Court Clinic employed trauma specialist Bessel van der Kolk, as well as other social workers, who were among the first to develop the diagnosis of PTSD (Smith College School for Social Work, 2007).

Despite the loss of VA funding and the schools absorption with the civil rights movement, several significant changes occurred between 1958 and 1974 under Dean Patel's leadership which impacted academics offered to students at the Smith graduate school, and services received by veterans suffering from combat-related trauma. During Dean Patel's tenure, for the first time in its history, the masters program at the Smith College School for Social Work opened its admission criteria to include male graduates of approved colleges and universities. In addition, whereas prior preference was given to applicants between the ages of twenty-five and forty, in the late 1960's and early 1970's the age criteria was dropped to include applicants between the ages of twenty-one and forty (Courses of Instruction, 1969-1970, p. 23). Considering the average age of an infantry soldier during the Vietnam War was 20 years old, perhaps by lowering the preferential age requirement for graduate students Parad created a group of male psychiatric social workers for whom some veterans felt more comfortable in their communication. Whether or not this is the case, it can certainly be argued that some male veterans suffering from trauma-related combat do favor working with male therapists, especially if they have a similar combat experience.

An additional change occurred within the 1969-1970 Smith graduate school curriculums which would have enduring implications on mental health treatment



interventions for PTSD. One of the first incidences in which the term “psychosocial” was used in reference to diagnostic casework can be found in an article written by Gordon Hamilton in 1937 entitled *Basic Concepts in Social Casework*, (Hollis, 1970).

Acknowledging the contributions of several other individuals and schools (including the Smith College School for Social Work) in the development of the approach, Florence Hollis, who studied under Bertha Capon Reynolds, viewed the psychosocial perspective as one which:

Is essentially a system theory approach to casework. The major system to which diagnosis and treatment are addressed is the person-in-situation gestalt or configuration [whereby] the person to be helped – or treated, if you prefer – must be seen in the context of his interactions or transactions with the external world.

(Hollis, 1970, p. 35).

The psychosocial approach to casework was riddled throughout the Smith graduate school curriculum, with treatment approach focusing on five aspects consisting of worker support of client needs; an “other-centered” methodology; the worker’s “scientific objectivity;” client empowerment and self determination; and the worker’s direct influence (suggestion and advice) (Hollis, 1970, p. 37). The overall premise of the psychosocial approach to casework is extremely relative today, with one additional component – that of the biological.

In the early years of the Smith College School for Social Work, great emphasis was placed on educating students in the fields of medicine and biology, with coursework examining the “essentials of anatomy and physiology and the etiology of disease and

methods of transmission” required during the students first summer session (Courses of Instruction, 1921-1922, p. 11). Emphasis on biological study seemed to dissipate over the years, perhaps because the medical social work specialization was dropped from the prospectus, or maybe because emphasis of casework focused on the client’s psychosocial development. Whatever the reasoning, in the curriculums of 1969-1970 a new word appeared in the description of course 151 entitled *Personality Development II* which embraced the biological concept of pathology and intervention once again – biopsychosocial (Courses of Instruction, 1969-1970, p. 27). Reading “this course further delineates the concept of illness as a failure in biopsychosocial adaptation” (p. 27) the course catalogue introduces for the first time the biopsychosocial perspective which has become instrumental in the treatment of combat-related trauma today in its systemic approach to practice.

Current pharmacotherapy treatment approaches to PTSD, as discussed in Chapter III of this thesis, includes the use of Selective Serotonin Reuptake Inhibitors (SSRI’s) which have proven to have a significant effect on the reduction of all PTSD symptom clusters (Friedman, Davidson, Mellman, & Southwick, 2000), with sertraline hydrochloride (zoloft) and paroxetine hydrochloride (paxil) the only two drugs to receive approval from the Federal Food and Drug Administration for the specific treatment of PTSD.

The development of psychopharmacological drugs over the past several years has been influenced, in part, by substantial increases in research examining the physiological and neurobiological correlations to PTSD. Repetitive trauma has been known to impair

the development of higher level brain functioning, which potentially leads to poor impulse control and the consequent inability to modulate emotional arousal (Perry, 1997). Poor impulse control and difficulties modulating affect are two significant symptoms associated with PTSD; hence understanding a possible neurobiological etiology is extremely important in furthering our biopsychosocial understanding of this disorder.

During the early stages of the Vietnam War, preliminary statistics citing psychiatric casualty rates of 12 per 1000 suggested that military and psychiatric methods of dealing with acute combat reaction had all but cured the illness (DeFazio, 1978). Experts felt that forward psychiatry, when combined with frequent periods of rest and relaxation, combat free intervals devoid of shelling and bombardment, and a limited tour of duty (365 days), was the key to defeating combat-related trauma (DeFazio). As veterans returned and began to complain of symptoms such as growing indifference, depression, mistrust, insomnia, and impatience with relationships and situations anywhere from nine to 60 months after demobilization, mental health experts realized that earlier statistics were not capturing the true evolution of this condition (Shatan, 1978).

Not surprisingly, when the National Vietnam Veterans Readjustment Study (NVVRS) was published in 1990, data pertaining to lifetime prevalence of PTSD were reported at 30.9 percent among male theater veterans and 26.9 percent among females (Kulka et al., 1990). The study also reported that Vietnam veterans were significantly more likely to have readjustment problems and issues pertaining to marital adjustment and general family functioning. The idea that Vietnam veterans with PTSD were having

difficulties readjusting to societal expectations and familial relationships was not a revelation. In 1978 Stanton & Figley wrote that in the aftermath of Vietnam the necessity of treating the veteran within the family system was an essential intervention, as “the family system has potential for both maintaining and eliminating the disorder” (p. 283).

Smith’s slight shift from individual to systemic perspective, as evidenced by the incorporation of the biopsychosocial approach, encouraged the evolution of family therapy within the graduate schools curriculum. In the early 1970’s two courses entitled *Family Treatment* were added to the curriculum – number 329 which “draws on knowledge of individual dynamics, considers the contribution of theories explaining family interaction, and examines the resultant criteria applicable to family diagnosis and treatment planning;” and course number 529 which “concerns itself with examination of treatment methods *emphasizing goals of a family unit as distinguished from goals for an individual within a family*” (Courses of Instruction, 1974-1975, p. 15). Students participating in family therapy coursework were learning cutting edge treatments with regards to Vietnam veterans presenting with combat-related trauma, as they were learning to intervene from a systemic perspective; placing less burden on the shoulders of the soldier and deviating somewhat from the earlier diagnostic, pathological, perspective.

### *Contemporary Developments*

Treatment of combat-related trauma after the Vietnam War and into the Persian Gulf conflict became much more biopsychosocial in its methodology; extremely relevant considering the biological, social, and psychological components of the illness itself which this thesis has reviewed historically beginning with World War I. Smith College

School for Social Work has continued to support mental health treatment of soldiers from an academic perspective by endorsing specific treatment paradigms within its curriculum and understanding the need for a systemic approach. In addition, the graduate school supports students by publishing research efforts among those committed to the treatment of combat-related PTSD. The entire 1990-1991 issue of the Smith College School for Social Work Journal dedicated its pages to Gulf War concerns, with several of the articles discussing the relevance of war among children (Smith College School for Social Work, 2007).

Curriculum also continues to evolve. In 1979 the course *Brief Treatment* was offered, with the course description reading “whether functioning is disturbed by stress which interrupts development or mobilizes regressive adaptation, the optimal treatment goal may frequently be rapid restoration of functioning” (Courses of Instruction, 1979-1980, p. 32). It is within this edition of Courses of Instruction where the term “clinical social work” made its debut under Development and Objectives of the School (p. 5). In 1985 the curriculum presented *Couples Therapy; Psychiatric Emergencies: Assessment and Intervention*; and *Brief Dynamic Psychotherapy* as possible electives for interested students (Courses of Instruction, pp., 33, 34). And in the 1994-1995 syllabus the class *Psychic Traumatization: Theory and Practice* appeared, discussing “clinical assessment and treatment of individual, family, group and societal responses to catastrophic stressors such as rape, *military combat*, civilian crime, major accidents, natural and toxic disasters, refugee flight, and genocide” (Courses of Instruction, 1994-1995, p. 19).

Over the past ten years or so a growing number of elective courses promoting the assessment, diagnosis, and treatment of trauma have found their way into Smith curriculum and include: *Collective Trauma: The Impact of Intercommunal Violence on Individuals, Communities, and Cultures*; *Violence: A Systemic Approach to Assessment and Intervention*; *Crisis Intervention*; *Mental Health Responses to Disasters in a Community Context*; and *Clinical Practice with Traumatized Children and Families* (Courses of Instruction, 2006-2007). While such course work is advantageous to anyone interested in trauma treatment, minimal instruction pertains specifically to combat-related trauma. With regards to clinical treatment focus, most courses within Smith's core curriculum continue to endorse a psychodynamic perspective and the four psychologies most discussed and referred to within the program are Drive/Structural Theory, Ego Psychology, Self Psychology, and Object Relations.

Many courses are offered within the Smith graduate schools curriculum which supplement treatment interventions for combat-related trauma and support a biopsychosocial approach. Coursework examining sociocultural concepts garners further understanding pertaining to issues of ethnicity, race, class, gender, sexual orientation, religion, age, and disability. Gender studies offer alternative views with regards to identity, coupling, sexuality, parenting, and alternative family forms. The research sequence, inclusive of the thesis, promotes independent thinking, and the ability to develop a point of view pertaining to social issues from a scientific standpoint. And classes examining social welfare policies offer historical and contemporary analyses of

pertinent issues such as welfare reform, social security, and managed care which impact all of our clients - including those seeking assistance for combat-related trauma.

### *Case Study*

For the purpose of relating how current students from the Smith College School of Social Work understand and treat combat-related trauma, the following case study was written by this author during her second year internship in one of the busiest VA hospitals located in Houston, TX. All graduate students from Smith are required to write two comprehensive case studies during their internship rotations and they follow instructions set forth in the Smith College School for Social Works' *Guidelines for Field Practicum* (2006-2007). While only selective elements of this case study will be presented within the confines of this thesis, the full case study entitled "Never Surrender" can be found within the schools 2007 academic records.

Paul (pseudonym) was an average-sized 37-year-old white male whose family was of working-class socio-economic standing. He was an only child, divorced, had no children, and was not in touch with any family members during the time of treatment. Paul worked as a merchant seaman on tug boats full-time, for 30-60 days at a stretch, and made a very good living. He lost his home and all of his belongings in Hurricane Katrina two years prior to beginning treatment, and still had yet to find a new place to live. He kept a few belongings over at a friend's place but when he disembarked from the boat after 30 or 60 days of continuous work he usually rented a hotel room for 2 weeks while on leave. Paul had served as an elite member of the Army Rangers Airborne Unit during the Persian Gulf War in 1991 and the Battle of Mogadishu (also known as "The Day of

the Rangers”) in 1993. He had an extensive combat history from both wars and suffered from chronic, combat-related, post-traumatic stress disorder (PTSD). Paul was raised Catholic but no longer formally practiced. Except for fellow employees on the boat he was fairly isolated and had few friends.

Paul was attractive, fairly fit, and clean-shaven. His forearms exhibited a series of tattoos which he had completed over the years – all relating to his Army Ranger service. He presented with good eye contact and a speech pattern of normal rate and rhythm. He loved to talk and had a very timbered voice. For the most part Paul’s affect was constricted, quality was anxious, mood elevated. Paul’s perceptual processes were essentially coherent, but thought content was filled with excessive survivor guilt. He endorsed intermittent A/V hallucinations “seeing people I know are dead,” and “hearing noises from the battlefield.” Paul’s PTSD had been diagnosed several years earlier at a VA facility in another state, but he had never sought ongoing treatment for his symptoms which included the re-experiencing of traumatic combat events to which he had been exposed; avoidance of all things, people, situations, etc. that reminded him of the events; and hypervigilance.

Paul had a past history of suicide attempts and chronic suicidal ideation, as well as a background rich in alcohol and substance abuse. During his leave from the boat he would drink excessively – all past suicide attempts had occurred either during or after an alcoholic binge. On this particular occasion Paul had tried to kill himself with an overdose of Tylenol and a loaded gun after a binge drinking spree, but he was found by an acquaintance before he could follow through. He was admitted inpatient through the



VA hospital and had been on the ward for about 24 hours before I had a chance to meet with him. I had earlier requested that combat-trauma cases be forwarded to me because of my interests in PTSD, and I was fortunate to be assigned as Paul's inpatient therapist upon admittance.

In treating Paul I first conducted a psychosocial assessment which included a brief synopsis detailing identifying information, referral source, presenting problem and history of the problem. The assessment then delved into developmental history, personal history, family background, medical history, socio-cultural, economic, and religion/spirituality background, and Paul's military history. Information regarding past psychiatric hospitalizations and treatment was obtained through electronic data which links all VA hospitals throughout the U.S. In addition, social and environmental stressors and barriers to care were identified as well as strengths which could be utilized during Paul's ongoing treatment. Finally, military trauma was confirmed through VA records and Paul's own accounts, with risk and protective factors acknowledged.

Protective factors included pre-deployment training (physical fitness; stress coping skills; sleep discipline; task allocation and management); exposure to the Army (education; discipline; unit cohesion); and his elite Ranger training which required incredible resilience and fitness, and truly relied on unit solidarity. "Never Surrender" is the Ranger motto, along with "with a tab or on a slab," denoting that soldiers either return with their Ranger insignia sewn tight on their uniform, or they return dead. Risk factors for Paul having developed PTSD included childhood adversity (he was abandoned by his mother when he was 4 years old; physically abused by a stepmother; raised by an

alcoholic father who was seldom present; arrested for attempted murder of an opposing gang member when he was 15 years old; followed by two years in a psychiatric hospital); lack of social support; multiple deployments; multiple trauma experiences; and delayed assistance in seeking ongoing treatment. Risk and protective factors for the development of PTSD are further explored within Chapter III of this thesis.

Paul experienced several deadly traumatic incidents while serving in combat in Mogadishu and Iraq. In Mogadishu during October of 1993, Paul was in a firefight with 160 fellow Rangers against more than 2,000 Somali militiamen which lasted over 24 hrs before U.S. reinforcements were brought in. When the battle ended, 18 U.S. soldiers had been killed; 73 seriously wounded; and more than 1,000 militiamen and Somali civilians dead. Many of the dead Somali's were young, 12-year-old male soldiers, who had been loyal to warlord Mohamed Farrah Aidid. Several of Paul's trauma memories contained visions of the role he played in their deaths. The movie *Black Hawk Down: a Story of Modern War* portrayed the horrendous battle and used Paul's experiences in depicting one of the main characters.

Although Paul's ego functioning was impaired, he demonstrated ego strength in his ability to effectively verbalize thoughts/ideas which were very goal-directed. Paul also had amazing resilience which had protected him through several combat experiences, in addition to obvious intelligence, good physical health, and a desire to work and be, in his words, a "contributing member of society." Conversely, Paul struggled with low self-esteem, poor judgment and insight, and an inability to form and

maintain coherent, respectful, healthy relationships. His only marriage had been brief and unsatisfactory, leaving him with very few happy memories.

Many ego defenses in which Paul relied were developmentally early and/or neurotic in nature. He often denied the true extent of his anxiety and trauma by drinking excessively and acting out. He consciously forced himself to block out trauma memories as they caused him great pain and he spoke about trying to bury them so he could “just get on with it.” Besides suppression, Paul also utilized depersonalization when talking about his aggressive behaviors and actions, as though he was a participant but not really responsible. Depersonalization was also utilized when Paul recalled dreams or flashbacks of trauma memories, and several times in session when Paul discussed past suicide attempts, he unknowingly described his use of dissociative detachment.

Paul’s treatment goals were to leave the inpatient ward; feel more in control of his life; resolve the issues he had pertaining to guilt, shame, paranoia, and lack of self-esteem; to develop healthy, close, interpersonal relationships; and to be happy. Paul was happiest when he was on the boat. He felt soothed by the sound of the engines, and the routine of the mechanical checklist which he was required to initiate every few hours kept his mind focused. But the minute he stepped off the boat he became overwhelmed and began his search for alcohol, hoping the substance would keep him calm and allow him to function normally. Unfortunately, Paul refused to believe that alcohol was a barrier to his recovery and despite several attempts to show him how destructive a role alcohol was playing in his life he rejected all interventions in this area.

Understanding Paul's treatment objectives, short term crisis interventions were initiated. I worked to establish a therapeutic relationship with Paul that was honest and supportive. We both worked to understand his suicidal feelings and causes of unbearable stress, and we discussed the problems in which the suicide attempt was supposed to have resolved. Specific problem issues (i.e., lack of social support; concerns that if he stayed in treatment he would not be able to generate an income, etc.) were defined and verbalized to give Paul more control, and available support through the VA's Trauma Recovery Program (TRP) was initiated. TRP is a partial hospitalization program which offers individual treatment and group work for veterans suffering from PTSD. Paul was also placed in an experimental program called Critical Treatment Intervention (CTI) which has ties to TRP and offers participants a rent-free environment along with additional social supports while going through trauma treatment. Two psychiatrists worked extensively with Paul throughout his treatment at the VA, and they utilized several medications, including two SSRI's, to stabilize his condition.

When Paul was released from the hospital he continued to seek treatment for a short period of time. We worked at increasing his feelings of direction and safety in all areas of his life; in giving him tools to help him manage ongoing symptoms; and establishing support beyond the VA system. Long term treatment goals, including Paul's aim to eliminate feelings of guilt and shame that were tied to his combat experiences, and his desire to develop and maintain a sense of meaning in his life, were discussed and processed throughout. Within the therapeutic environment Paul could speak indefinitely about the trauma he had been exposed to – both during combat and as a child – and I

often had to hold him back so he would not become too vulnerable and unable to function once he left.

Paul's treatment was certainly systemic in approach. Pharmacotherapy was utilized throughout and medications were prescribed that helped Paul deal with his mood dysregulation, paranoia, and hypervigilance. VA support was extensive in all areas. Paul participated in several daily TRP groups which had both psychoeducational and processing components, and which addressed problem areas including Paul's isolation and lack of social support. Working among peers in TRP helped him to normalize his PTSD symptoms; albeit he felt his symptoms were more problematic than those of his fellow veterans. Paul's residential and external support via CTI was far-reaching and he had his own case manager as well as access to the CTI-TRP psychiatrist.

Within individual therapy I used several different theoretical perspectives to better inform my interventions – primarily TFCBT, Freud's view of anxiety, and Ego Psychology.

TFCBT (Trauma Focused Cognitive Behavioral Therapy) was a course I had taken and utilized while working with victims of sexual and physical assault during my first internship. The initial modules involve psychoeducational pieces on trauma in its various forms, along with skills to help regulate affect and mood. The idea is to provide the client with a "tool box" of skills they can utilize which will give them some sense of control over their situation by rapid symptom removal. TFCBT is an excellent resource for all therapists working with trauma victims – both civilian and combat-related.

Interesting to note: the course *Traumatized Children and Families* at the Smith graduate school has just this year (2007) changed its curriculum to focus primarily on TFCBT.

In addition, as Paul was experiencing overwhelming feelings of anxiety that pre-existing defense mechanisms were having difficulty containing, I turned to Freud in order to garner a better understanding of his anxiety from a developmental perspective, Melano-Flanagan, and Hertz (1996) write “Defense mechanisms are automatically triggered when the ego becomes conscious of anxiety, an inherently distressing emotion that individuals experience along a continuum ranging from mild discomfort to intolerable panic” (p. 80). When the ego perceives anxiety it utilizes defenses learned during the psychosexual stages of developmental to “preserve emotional well being and limit the degree of functional impairment” (p. 81). In examining Paul’s childhood it appeared that his level of anxiety seemed to stem from “fear of loss of the object;” usually experienced at a very early stage in life, and associated with fear of abandonment from a primary caretaker.

According to Berzoff et al. (1996), “fear of loss of the object” manifests in adults through “intensely dependent and/or clinging behavior, or through acting out which may be antisocial in nature. Acting out unconsciously asserts that the individual does not need a caregiver, is not anxious, and is capable of taking perfectly good care of her/himself without any assistance from anyone else” (p. 82). Paul’s fear of abandonment became a reality at four years old when he was given up by both his mother and his father. Paul’s father eventually re-surfaced, but the damage had already been done. It is entirely possible that when Paul’s father reappeared he was perceived unconsciously by Paul as

being unable to heal this fear, and his father's wife (Paul's abusive stepmother) only served to exacerbate his anxieties. Not only does Berzoff et al.'s description regarding adult manifestation of this type of anxiety help to explain Paul's acting out behaviors throughout, it validated my concerns that early and present relationship issues might have had something to do with his inability to trust. Underlying fears about connecting with anyone were evidenced in his avoidant and fearful attachment style which was played out in therapy, and explained why he had not been able to maintain ongoing treatment for any length of time. He did not feel safe enough to connect for fear of being abandoned once again. For further enlightenment I turned to Ego psychology.

I utilized Ego psychology because this theoretical approach tends to focus attention on the "minds development in relation with the social and physical world" and provides a framework for "repairing the effects of arrested, incomplete, or distorted psychosocial development, and facilitating a better fit between the psychological needs of the individual and the normative expectations of society" (Berzoff et al., 1996, p.68). While Paul had endured a great deal of trauma as a result of his military service, he also had ego deficits dating back to his early childhood development. This flexible approach seemed to consider both implications and I utilized the perspective in several arenas. First and foremost I needed to get an idea of Paul's ego functions and use of defense mechanisms – as previously described. Secondly, I wanted to further understand Paul's development via Erikson's psychosocial stages. He had endured such a tumultuous childhood that I wanted to make sure I wasn't missing relative issues, etc. which had incurred prior to his traumatic experiences as a soldier, or those which may have occurred

in tantamount. I was particularly interested in Paul's personal interpretation of events around the age of 12, as this was approximately the age of the child soldiers he had killed during the firefight in Somalia.

Throughout treatment Paul described his time in the psychiatric hospital, and additional events leading up to his joining the Army when he was 20 years old. Through discussion and review it became obvious that he had become trapped somewhere between Erikson's trust vs. mis-trust and initiative vs. guilt – between his first year of life and the time he turned six. This seemed to confer with Freud's developmental stage pertaining to Paul's type of anxiety. Paul had developed a fair amount of distrust in the world around him at a very early age after his mother abandoned him, which was compounded by his father's ambivalent parenting techniques. Shame and doubt won out over autonomy between the ages of one and three – the age where children begin to develop their sense of self-esteem and self-worth. By the time he turned six or seven he was living with his abusive step mother who appeared to stifle any sense of initiative Paul may have had, consequentially making Paul feel safer in the role of "follower" vs. "leader."

By the time Paul turned 12 he was already feeling inferior, doubting his own abilities, and desperate to feel like he belonged. While his grandmother served as a fairly stable support through many of his early years, in his mind he had managed to disappoint her as well when he started running around with the wrong crowd. Confused over his role in life he joined gangs to find some sense of identity – something he never truly found until he joined the Army and the elite branch of Army Rangers. The Army Rangers were everything to him and momentarily pieced together ego deficits long in forming.



Much of my focus with Paul was ego supportive in nature – working on his current (“here and now”) behavior and conscious thoughts and feelings, with some selective focus on his past to garner a better understanding of his ego strengths and weaknesses. Ensuring that Paul had the resources to maintain ego support outside of therapy was a group effort, as previously explained, and a major focus of his therapeutic team was to improve and modify his environmental conditions (i.e., residence, employment, etc.). In therapy we focused on Paul’s strengths to facilitate his ego coping and give him a sense of mastery – placing emphasis on his ability to endure and always pull himself through difficult times.

I deliberately chose not to use an ego modifying approach in Paul’s treatment plan because I did not think that he had the necessary ego strength, and I was also concerned about time constraints. Paul was becoming increasingly more concerned about financial issues and was verbalizing his desire to go back to work on the boat. Consequentially, characterological issues concerning an Axis II deferment were never directly addressed. While interpretation of transference and countertransference issues took place during my supervision, which is more modifying in nature, I did not *verbally* bring that interpretation into the therapeutic relationship. I once observed out loud that Paul worked hard to control what went on in session (i.e., his refusal to talk about what type of gang he had been involved with as an adolescent), and stated this was natural for someone who needed to be interpreted in a good light. While Paul readily acknowledged he did not want to be seen as “bad,” the narcissistic injury stemming from my comment was apparent, and I realized the discussion had been premature.

While Paul often remarked about how helpful therapy had been, and seemed to gaining much more control over his symptoms, approximately 5 weeks after hospitalization he chose to pull out of the TRP program and individual therapy. Of course this behavior was to be expected considering that one of the core symptom patterns of PTSD is avoidance, but it did not make the reality any easier to take from a clinician perspective. Paul returned to work on the boat where he felt more contained. Less than three weeks later he was readmitted to the ER after becoming drunk and disorderly on another leave. He stated that the problem was the psychiatric medications he was taking – they did not seem to mix with alcohol. He was kept in the hospital overnight and released back into the CTI program where he stayed one week before once again leaving for work. By this time I had already been moved to another rotation but I stopped in to visit him briefly. It was apparent that he was scared to death of the path he was on but he could not seem to stop. Paul was readmitted through triage for suspected medication and alcohol overdose on two additional occasions, but he was always released before therapy appointments could be initiated. I saw Paul occasionally while on rounds, and my supervisor reported that he always seemed to brighten up after our brief conversations, but my offer to continue working with him in individual sessions went unheeded, and he did not re-enroll in TRP.

### *Conclusions*

I believe this case study reflects current perspectives in the assessment, diagnosis, and treatment of combat-related trauma from a Smith graduate student stance. While some work was initiated from a cognitive behavioral perspective treatment focus was

primarily psychodynamic in design, but this modality has come a long way from WWI where Freud was the only source from which to draw. In comparing Ms. Hegner's approach from 1921 to current methodology as portrayed in the case of Paul, many differences in the clinical social work approach can be observed. The most obvious distinction pertains to the role of the psychiatric, or clinical, social worker. While graduating students in the early 1920's were largely considered psychiatric aides, social workers functioning as inpatient therapists within the VA system today can be viewed as primary therapists, with psychiatry moving further into the role of medication management.

Although there is much debate about this issue currently, and many psychiatrists still perform a psychotherapeutic role while managing client medications, this change has been partially brought about because of managed care which continues to reimburse by way of procedure based practices; the more time, skill, resources, and risk the procedure requires the greater the remuneration (Stoline, Goldman, & Sharfstein, 2000). "Even with managed care companies that allow psychiatrists to provide psychotherapy, their reimbursement to the psychiatrist is usually much greater for an hour filled with three or four medication appointments than it is for one psychotherapy session" (Gabbard, 2000, p. 115). Hence the emergence of a stronger role in psychotherapy for clinical social workers. Ever since the mid-1990's psychiatrists have not been the main providers of psychotherapy; with psychologists and "other mental health professionals" taking the more prominent role (Gabbard, 2000, p. 113).

The clinical social worker function has also changed with regards to the client-therapist relationship. No longer is treatment based solely on the social worker's abilities and knowledge as a change agent. As seen in the case of Paul, clients are experienced as capable of making their own treatment goals and decisions, and are considered very much from a strengths-based perspective. Perhaps this change stems from the way in which we now look at clients suffering from mental illness. History has demonstrated that in earlier years such individuals were looked upon as dysfunctional beings that might corrupt society with their very illness. Treatment focus was on separating such individuals from the rest of their community until they were deemed "normal" and could be reintegrated. Today mentally ill clients are considered to be individuals who already have what it takes to enjoy a productive, self-satisfying life, and we look to the community and the client's environment to assist in their overall treatment intervention. Clients have become the catalysts in the treatment paradigm – not the clinical social worker. While Smith clinical social workers are still trained to look beyond the needs presented by the client, understand the causative factors contributing to their illness, and envision treatment goals beyond those which the client may articulate, unless the client verbalizes a desire to do the work and commit to such a process we are not encouraged to work harder than the client to help them realize such goals.

An additional difference pertaining to contemporary clinical social work treatment of combat-related trauma, as discussed earlier in this chapter, relates to the current focus on a systemic, biopsychosocial approach. This development allows clinicians to treat PTSD via psychopharmacology, an abundance of psychological

treatment paradigms, and with renewed understanding of the importance of social support structures prior to deployment and during reintegration. While psychodynamic theory is utilized to garner further insight and assist in directing treatment, other methods including psycho-education, cognitive-behavioral therapy, and EMDR are utilized to normalize symptoms and offer immediate symptom relief; providing clients with useful tools that help them feel more in control of their illness and their life.

Similarities between Smith's earlier approach to combat-related trauma and current methodology can also be found when comparing Ms. Hegner's work to current examples. Smith social work students are still taught the significance of a comprehensive and well developed psychosocial assessment. While the words eugenics and heredity are no longer considered politically correct, consideration of family history as it may relate to current symptomatology is assessed. However, research now tells us that the primary factor in developing PTSD is the trauma experience itself, and the more severe the combat exposure is, the greater the likelihood of developing chronicity (Engdahl et al., 1997; Hoge et al., 2004; Kang et al., 2003). We also understand there is no one preexisting personality trait or disposition that makes certain people more likely to become combat stress casualties sooner than others (Gifford, 2006), and anyone can break under the stress of combat (Brill & Bebe, 1952). Among other things, a thorough psychosocial assessment includes inquiries about possible traumatic experiences and traumatic brain injury, as discussed in Chapter VI, as well as possible individual and family combat exposure.

While the Smith College School for Social Work continues to provide academic support for students interested in working with clients exposed to trauma, and financial scholarship for military personnel who wish to complete a degree in clinical social work, I believe additional course work focusing specifically on the unique phenomenon of combat-related trauma, as distinguished from civilian trauma, would be beneficial given the fact that we are currently at war and expecting high combat-related PTSD casualties over the next several years (Bilmes, 2007).

As discussed within Chapter III of this thesis, there are significant differences between civilian trauma and combat trauma which need to be acknowledged when determining treatment interventions. Whereas civilian trauma can be random and unsuspecting, from a military perspective individual encounters with stressful events are supposed to be anticipated. Soldiers go through rigorous physical fitness training, stress-coping skills training, sleep discipline, and task allocation and management during the pre-deployment stage in order to instill a sense of unit cohesion, mastery, and behavioral response in the face of traumatic war events. But soldiers can never be completely prepared for the experience of war. Stressors unique to warfare which include ambiguous enemy fire and attack under the direst of circumstances such as malnutrition, constant fear of death or injury, and the horror of witnessing war carnage (Figley, 2006) cannot be taught through pre-deployment conditioning.

But because soldiers have endured all the hardships associated with pre-deployment training, unlike civilians, they are expected to manage their responses to traumatic experiences making it all the more difficult for them to seek help. Soldiers are

conditioned to believe that any break in mental vigor as a result of a traumatic encounter is not only a reflection of the cohesiveness of the soldier's unit, or lack thereof, it is a moral disgrace that can be prevented if one chooses to do so (Strecker, 1944). In WWII, aircrew in the Royal Air Force who were labeled as having a lack of moral fiber lost their flying privileges and were banished to neuropsychiatric centers for assessment and treatment. Those who were unable to return to active duty were "either discharged from the air force, reduced to the ranks, or transferred to the army;" in other words, demoted (Jones & Wessely, 2005, p. 97). Today, the number of returning veterans from Iraq seeking mental health services is estimated to be between 25 and 35 percent (APA, 2007; Figley, 2006; Hoge et al., 2006), with a further 60 percent unlikely to seek help due to fears of stigmatization or loss of career advancement opportunities (Figley, 2006).

Referring back to the Brewin et al. meta-analysis (2000; Chapter III) comparing civilian and military risk factors for PTSD, several differences among the cohorts were revealed. Disparities with regards to age (younger age at exposure to trauma was only a risk factor in the military), gender (gender effect was significant amidst civilian studies but was nonexistent among combat veterans), race (race did not predict PTSD at all in any female samples, but it was indicated as a significant predictor in male military samples prior to controlling for combat exposure), and trauma severity (impact of which was significantly greater among combat veterans than among civilian trauma victims) led researchers to note that findings "clearly point up the heterogeneity of the disorder in different settings and warn against attempts to build a general vulnerability model for all cases of PTSD at this time" (p. 756).

In another study examining chronic Vietnam veteran PTSD with acute civilian PTSD precipitated by a motor vehicle accident, researchers discovered major differences between the two groups with regards to source of referral, age, sex, socioeconomic level, nature and timing of stressor, character of the intrusive and avoidance symptoms, and treatment noncompliance behaviors (Burstein et al., 1988). The researchers concluded that differences were “of sufficient magnitude to call into question the feasibility, at this time, of constructing generalizations regarding PTSD” (p. 245).

Those who treat trauma understand that the nature in which the trauma transpires and the ecological factors associated with it can accelerate or ameliorate sequelae. Research indicates that individuals exposed to the battlefield experience are more severely affected by depression, anxiety, interpersonal sensitivity, and somatization than those experiencing civilian terrorism or work and traffic accidents (Amir, et al., 1996). War is a unique arena whereby soldiers can be victims one minute and perpetrators the next. Combat veterans are trained to lose their individuality and conditioned to become part of a tight, cohesive, working unit prior to their deployment. Interventions for those exposed to trauma are aggressive and speedy with little time allotted for rest and recovery before soldiers are sent back into the fray of war. As a result they find themselves, once again, vulnerable to the many forms of trauma found in the heat of battle. The stigma associated with the treatment of combat related trauma is powerful; consequently many soldiers decide to forgo help. The very nature by which soldiers are exposed to trauma, treated, and reintegrated appears to be poles apart from those experiencing other forms of



trauma, which must, at the end of the day, significantly impact treatment interventions and, accordingly, academic study.

The purpose of this chapter was to demonstrate how the Smith College School for Social Work has evolved over the century with regards to its focus on combat-related trauma, and I trust it has served this purpose. Smaller, yet equally significant, changes over the years also reflect the current focus of clinical social work at Smith. While individuals seeking treatment were once referred to as “patients,” they are now addressed as “clients” indicating a more equal footing. Mental health social workers during the first several decades of the twentieth century were called “psychiatric;” they now prefer the term “clinical” which implies competence and professional standards.

Initially the school’s graduate program consisted of 8 months of didactic study for women; to date it is a 27-month intensive training program for both women and men which has approximately 350 Masters students in almost 200 agencies, hospitals and clinics across the U.S., and 77 Doctoral students who are both in-residence and post-residence (Smith College School for Social Work, 2007). But while the war-time rationale in which the school was first founded has changed and developed to encompass clinical work in all areas of mental health, the need for clinical social workers specializing in combat-related trauma is now greater than ever. A recent APA report (2007) disclosed a 40 percent vacancy rate in active duty psychologists in the Army and Navy, which has created increased work load among remaining mental health personnel, including clinical social work, and an ensuing high attrition rate. To this end the early reflections of Mary C. Jarrett are as relevant today as they were in 1918:

The demand for especially trained social workers in this field has been far greater than supply. The approaching problems of war neuroses made it clear that emergency training should be undertaken. The services of social workers in the care of mental and nervous patients, proved indispensable on a small scale here and there in civilian hospitals, would evidently be required on a large scale in the reconstruction program for military cases. (p. 593)

## CHAPTER VIII

### DISCUSSION

The intent of this historical thesis was to examine the biopsychosocial effects of combat-related trauma in veterans with the purpose of guiding future treatment. The research examined voluminous literature pertaining to combat-related trauma from the First World War (WWI) to current conditions experienced in Afghanistan and Iraq so as to compare and contrast the biopsychosocial effects of trauma from a historical war-time lens. This effort also featured a clinical social work perspective on how the understanding and treatment of trauma has evolved throughout the years beginning with the first students of The Training School of Psychiatric Social Work at Smith College in 1918. Within the literature several gaps and discrepancies occurred while many new insights were gained. This chapter will synthesize the aforementioned in an effort to direct future treatment interventions.

#### *Definition*

Symptoms characteristic of PTSD fall into three main categories: intrusion, avoidance, and increased arousal. Combat-related PTSD can be caused by direct combat, serving in medical units, seeking out enemy combatants, work involving the registration of graves, sexual assault or severe sexual harassment, driving vehicles at risk for encountering IED's, and patrolling the streets (IOM, 2006). Biological, intrapsychic, interpersonal, and situational factors can increase stress casualties, but they can also serve

as protective factors against the disorder. To date there exists no single biomarker which can diagnose PTSD or assess the risk of its development (IOM, 2006), nor is there one single preexisting personality trait or disposition that makes certain people more likely to become combat stress casualties sooner than others (Gifford, 2006). However, research informs us that the greater the degree or severity of combat exposure, the greater the probability of developing combat-related trauma, and the longer the duration of symptoms (Engdahl et al., 1997; Hoge et al., 2004; Kang et al., 2003).

While symptomatology has evolved since before WWI, and has received an assortment of labels, it is clear from the variety of research stated that these conditions are referring to what we now term PTSD (Monahan & Neidel-Greenlee, 2003; van der Kolk et al., 1996), but history suggests that pathology of the illness is dynamic and influenced by culture, politics, technology, treatment advances, the discovery of new diseases and cures, and wartime conditions. The high comorbidity of mood, dissociative, and anxiety disorders; along with substance abuse, somatic complaints, and character pathology associated with PTSD, have made the psychiatric diagnosis and ensuing treatment extremely challenging throughout the century (Kulka et al., 1990).

### *Differences*

Combat-related trauma, or combat-related PTSD, differs from civilian trauma in many ways. Research suggests that source of referral, age, sex, socioeconomic level, nature and timing of stressor, trauma severity, character of the intrusive and avoidance symptoms, and treatment noncompliance behaviors differ between chronic combat-related PTSD and acute civilian PTSD (Brewin et al., 2000; Burstein et al., 1988). In addition, the stigma associated with combat-related trauma is paralyzing. Because

soldiers have endured the hardships associated with pre-deployment training, unlike civilians, they are expected to manage their responses to traumatic experiences making it all the more difficult for them to seek help. Soldiers are conditioned to believe that any break in mental vigor as a result of a traumatic encounter is not only a reflection of the cohesiveness of the soldier's unit, or lack thereof, but it is a moral disgrace that can be prevented if one chooses to do so (Strecker, 1944).

### *Stigma*

A historical review suggests that the stigma associated with individuals diagnosed and treated for combat-related trauma has not improved over the years. During WWI, in part due to the pressures of social Darwinism and eugenics which promoted the concepts of individual differences and determinism, shell shock was considered by some to be a disease of the will (van der Kolk et al, 1996; Salmon, 1917) and treatment modalities often utilized “the full moral authority of the doctor to restore men to the Army” (Shephard, 1999, p. 34). Military perceptions that soldiers “refusing” a cure from combat-related trauma might drain the morale of fellow soldiers and cause a negative effect on American society created a stigma which continued during WWII, the Vietnam conflict, and is currently experienced by OIF and OEF combatants. In WWII American soldiers exhibiting trauma symptoms were looked upon by some as narcissists, psychopaths, or malingerers (Wagner, 1946). During the Vietnam War soldiers who exhibited trauma symptomatology were often dismissed as angry, uneducated and drug-prone. Due to the political and social climate of the 1960's and '70's veterans were left on their own to rally the field of mental health to formally acknowledge their combat-related trauma

symptoms. It was through their efforts in 1980 that the diagnosis of PTSD was formally acknowledged.

Today there are conflicting reports detailing perceptions of stigma in the U.S. armed forces. In the government sponsored 2006 MHAT – III report, key findings state that stigma associated with mental health care services has declined among OIF soldiers based on increasing numbers of soldiers seeking mental health care. A recent report conducted by the American Psychological Association (APA; 2007) disputes these claims, stating that more than 30 percent of all soldiers meet the criteria for a mental disorder, but only 23 to 40 percent of these men and women seek help. Figley (2006) claims that this number could be much higher; stating that as many as 60 percent of returning OIF and OEF members neglect to seek help due to fears of stigmatization and loss of career opportunities. While many in the military may still consider PTSD to be a diagnosis of shame, and continue to treat those afflicted with contempt, professional diagnosis and treatment of the illness has evolved primarily from the medical, or diagnostic, model of medicine, as well as the psychodynamic.

*“Bio”*

During WWI there were many who challenged the opinion that shell shock was a disease of the will, preferring to view the disorder as having a physiological component. Treatment included three hot meals a day, bed rest, sedatives, physical activity, and the brutal use of faradism when all else failed. During WWII the very term “combat fatigue” suggested that soldiers were simply exhausted from battle and needed a bit of rest and collation. For many, treatment included large doses of barbiturates and complete bed rest, with soldiers awakened only to eat and use the latrine (Monahan & Neidel-Greenlee,

2003). During the Korean War, the Vietnam War, OIF and OEF, psychiatrists and mental health professionals, who have prescribed to the medical model, have continued to treat combat exhaustion in a similar fashion with rest and replenishment the main ingredients to recovery.

The primary way in which the medical model of treatment for combat-related PTSD has been employed over the years has been through the concepts of PIE and BICEPTS. During WWI American, British, and French forces utilized the notion of forward psychiatry to achieve their main objective, which was to return soldiers to the battlefield as quickly as possible. Soldiers were treated close to the front lines; treatment was brief and simple; a positive therapeutic environment was encouraged; and the overall needs of the combat group were considered and compared to the individual needs of soldiers (Glass, 1954). PIE tactics were rediscovered in WWII and utilized during the Korean War, the Vietnam War, and continue to be used in OIF and OEF with little variation in technique.

Additional ways in which the medicalization of psychiatry has influenced assessment, diagnosis, and treatment of combat-related trauma throughout the century has been through electroconvulsive therapy, surgery (i.e. focal infection), psychopharmacology, and neuroscience, which all focus on an organic etiology. One of the most significant treatment outcomes of WWII was the recognition given to the psychiatric component in the development of certain somatic complaints (Deutsch, 1944). A high comorbidity between combat-related trauma and health problems such as heart disease, musculoskeletal problems and gastrointestinal complaints along with elevated risk behaviors such as smoking, alcohol and drug use, poor diet and lack of physical

activity have increased utilization of medical care services and encouraged ongoing research in psychosomatic medicine. Medicalized psychiatry places emphasis on scientific outcome and treatment modules which can empirically evaluate efficacy, such as those deemed cognitive and behavioral, with little support of psychodynamic and hypnotic-restructuring models.

### *“Psycho”*

Despite the influences of the medical paradigm over the years, and a lack of substantial empirical research conducted on efficacy of intervention, the psychodynamic model for treatment of combat-related trauma has been continuously employed since the First World War. During this conflict the use of psychoanalysis was practiced mainly by British practitioners who were given a free hand due to the overwhelming numbers of casualties, and lack of trained experts in the field (Holden, 1998). While abreaction was utilized by some military mental health professionals during WWI, assistance with the deliberate suppression of trauma memories also took place in order for soldiers to be returned to active duty as quickly as possible (Jones & Wessely, 2005). Early graduates of diagnostic schools of social work, in particular the Smith College School of Social Work, utilized Freudian theory as much as they could in their function as psychiatric aides; with environmental influences playing a lesser role (Reynolds, 1963).

Psychoanalysis became more accepted among civilians during the 1920's, '30's and '40's due to an outpouring of psychoanalytic literature and individualistic interest in the exploration of sexual liberation and the psyche. During WWII British psychiatrists utilized Freudian theory as they focused on soldier's unconscious suppression of fear, while American mental health professionals used both hypnosis and narcotherapy in



assisting with abreaction (Cardena et al., 2000; Jones & Wessely, 2005). Some specialists argued that abreaction should not be practiced without successful “re-integration” or “re-synthesis” of the traumatic memory taking place as well (Cardena et al., p. 265). Many professionals practiced group psychotherapy in WWII, and this intervention became one of the lasting treatment paradigms of the era (Jones & Wessely, 2005). Successful outcomes of psychodynamic treatment interventions, along with an in-pouring of funding from NIMH and a perceived shortage of analytically trained psychiatrists, led to an increase in medical residencies offered and greater status among those professionals who were psychodynamically trained.

As the Smith College graduate school curriculum evolved along with other diagnostic schools, focus on repressed unconscious material became secondary to more practical treatment approaches as they related to strengthening ego functioning, with added emphasis on the here and now, as it applied within the therapeutic relationship (Ehrenreich, 1985). The Great Depression, along with the birth of Functionalism, impacted the schools approach whereby the client became the central figure of his or her own recovery; no longer was healing based on the wise social worker who arrived “bearing gifts” (Reynolds, 1963). Currently the principles of Drive/Structural Theory, Ego Psychology, Self Psychology and Object Relations Theory serve as the main psychodynamic concentrations, with additional course work in cognitive behavioral therapy, brief dynamic psychotherapy, biology, and family and couples therapy more limited in their availability. No course work focusing primarily on combat-related trauma and its unique military culture is offered at this time; however, the elective *Psychic*

*Traumatization: Theory and Practice* does discuss some aspects of military combat within its overall curriculum.

While a psychodynamic approach was popular among psychiatrists in the 1950's and '60's, the rise of managed care over the years has served to remedicalize psychiatry, forcing psychiatrists to spend the majority of their time prescribing medications as opposed to providing psychotherapy. Residency programs in many hospitals are considering the abandonment of psychotherapy training because managed care companies are becoming less and less likely to cover the monetary claims (Gabbard, 2000). This has created more opportunity for psychologists, clinical social workers, and other mental health professionals to practice psychodynamic techniques, but all mental health practitioners have been influenced by the limitations of managed care.

#### *“Social”*

While a healthy reintegration of soldiers returning from war has always been a concern among American mental health care practitioners, it was not until the Vietnam crisis that empirical evidence appeared to support the need for social intervention. Once it was realized that symptoms of combat-related trauma could have delayed onset, the role of community, family, and interpersonal relationships in the pathology of the illness was questioned. In the late 1960's the development of community psychiatry assisted in the deinstitutionalization of America, creating a treatment focus of mental illness which stemmed from within the community instead of institutions which were counter-productive with regards to patient reintegration. The work of psychologists, clinical social workers and other mental health practitioners assisted in this approach by steering research towards the possible impact that interpersonal relationships had on maintaining

and eliminating war-related psychological and physical problems (Stanton & Figley, 1978).

Research today continues to support the need for a familial component to treatment. Some researchers have found that a leading post-trauma risk factor in the development of PTSD is lack of social support (Brewin et al., 2000), with additional studies finding that the effects of postwar stressful life events (e.g., job interruption, legal or financial difficulties, marital interruptions, criminal victimization, death of a child or a relative) can also be significant predictors of the illnesses development (King et al., 1998). In many cases social interventions such as family education, supportive housing, vocational rehabilitation, financial assistance, and assistance with claims are necessary elements to ensuring full recovery from PTSD. This social component to the biopsychosocial model of treatment intervention is now being studied from a pre-deployment, deployment and post-deployment perspective, but further research in this arena is warranted.

#### *Treatment - What Have We Learned?*

In synthesizing treatment methodologies of combat-related trauma from a historical and empirical perspective, it appears that many interventions have been successful, many have failed, and many still seek substantiation. The use of forward psychiatry in treating soldiers as quickly as possible after exposure to a traumatic incident has been judged a success by many researchers with soldiers reporting lower incidents of PTSD and psychiatric symptoms, less loneliness, better social functioning and higher rates of military return to combat units (Solomon & Benbenishty, 1986; Solomon et al., 2006). Return to duty statistics have often been recorded as high as 85 percent, but as

this thesis has demonstrated, we must approach these numbers cautiously as rates of recidivism are seldom recorded, and the main purpose of military psychiatry is sometimes at odds with individual well-being.

Cognitive behavioral techniques, EMDR, or pharmacotherapy have shown the most promising results in the treatment of PTSD on the home front (van der Kolk et al., 1996) with both group and individual treatment modalities empirically supported. Popular treatments used with PTSD include prolonged exposure (PE), stress inoculation training (SIT), and behavioral activation (BA); all of which have been tested vigorously in controlled studies with successful outcomes. EMDR is a form of exposure which has a cognitive component and it is reported to desensitize the soldier to the original trauma, significantly improving quality of life. Additional forms of supportive therapy frequently used include psychoeducation, coping skills, and compensatory strategies.

Finally, pharmacotherapy utilizing SSRI's has proven to have a significant effect on the reduction of all PTSD symptom clusters (Friedman et al., 2000). MAO inhibitors, tricyclic antidepressants, anticonvulsants, beta-adrenergic blockers, alpha<sup>2</sup>-adrenergic agonists and benzodiazepines are also utilized in the treatment of PTSD symptoms with varying results. In addition, researchers have found that pharmacotherapy appears to have a positive effect when paired with psychotherapy in the majority of patients treated for combat-related PTSD (Bleich et al., 1986).

Psychodynamic models turn to the unconscious in exploring clients' implications of traumatic loss and also help to strengthen ego functioning by bringing unconscious thoughts into the here and now by disabling symptoms and taking control of what was once overwhelming (Spiegel, 2000). Van der Kolk et al. (1996) have questioned the use

of these models in the treatment of PTSD due to the lack of empirical research on this approach, but the researchers readily acknowledge the possibility that clients seeking therapy may find such methods optimal in the reduction of associated features of the illness. These include affect dysregulation, dissociation, somatization, mood dysfunction, alterations in self perception and relationships, and alterations in systems of meaning.

These associated features of PTSD are part of the criteria used to determine a DESNOS, or complex PTSD, diagnosis, along with the existence of prolonged traumatic circumstances (Iribarren et al., 2005; van der Kolk, 2003). While DESNOS has yet to be officially recognized by the APA, research suggests that individuals informally diagnosed with DESNOS have a primary risk factor of early childhood trauma, unlike PTSD for which the primary risk factor is war zone exposure (Ford, 1999). Research also implies that both diagnoses are comorbid but distinct post-traumatic syndromes (Ford). If a DESNOS diagnosis is most closely associated with early childhood trauma along with prolonged traumatic exposure, and the features characterizing the illness include the associated features of PTSD, which van der Kolk et al. suggest might have the greatest response to psychodynamic methodologies, it stands to reason that a percentage of OIF and OEF soldiers might very well respond best to this approach despite gaps in research determining efficacy.

While we have no way of knowing how many veterans have experienced early childhood trauma, we do know that soldiers involved in direct combat are often subject to the ongoing and ambiguous threat of insurgent attacks, which would constitute a prolonged traumatic exposure (Iribarren et al., 2005). And whether or not different treatment modalities are used, depending on a PTSD or DESNOS diagnosis, at the very

least assessment for both diagnoses needs to take place and further research determining efficacy of psychodynamic approaches with regards to both core and associate symptoms of combat-related PTSD is justified.

Many therapies which have been utilized over the years have failed miserably in their attempts to treat combat-related trauma. The use of electroconvulsive therapy on PTSD symptomatology is now understood to be ineffective unless a comorbidity of major depression is present. Surgery to remove “infected” organs cited as causing all forms of mental illness finally ceased in the 1950’s. And many preventative methods have been empirically questioned by researchers, with some proving effective and others still seeking authentication.

In the years following WWI, the mental hygiene movement gained tremendous strength in its promotion of mental health and prevention of mental illness; and by WWII military psychiatrists had set up elaborate double screening processes concentrating on IQ scores, work history, and neurological organization. But it became apparent in a relatively short period of time that the screening procedures had failed as evidenced by large numbers of psychiatric casualties. The screening of new recruits continues to be utilized today in the hope of preventing seriously disturbed individuals further harm during exposure to combat. Unfortunately, unless the individual’s dysfunction is readily apparent, there is little evidence supporting efficacy (Wessely, 2005). Psychological screening would be useful if we were able to predict breakdown under combat stress conditions, but as we are still unable to do so, screening such as this often creates more harm than good (Jones & Wessely, 2005).

An additional form of prevention that has been used by the military since WWII, and questioned regarding effectiveness, is the practice of debriefing. While some research states that significant emotional benefits have been reported by troops who have experienced debriefing (Bisson et al., 2000), other studies state that its use in lessening the risk of the development of psychopathology has yet to be established (Raphael & Wooding, 2004; Wessely, 2005). The U.S. military has invested a great deal of time, personnel, and money in the practice of debriefing both in Iraq and Afghanistan, during deployment and when soldiers reintegrate, but further research needs to be conducted in this area before its true value can be determined.

One preventative factor, which is widely supported by research in both veteran and peacekeeping populations, is the concept of unit cohesion (Kardiner & Spiegel, 1947; Orsillo et al., 1998; Ritchie & Owens, 2004) which is introduced during basic training and constantly reinforced thereafter. The Army's pre-deployment regime of physical fitness training, stress-coping skills training, sleep discipline, and task allocation and management serve to make the soldier stronger and more capable of managing possible combat-stress reactions. When combined with military training and focus on group needs and goals in sharing the burden of battle, as opposed to individual desires, the concept of unit cohesion or esprit de corps becomes ingrained and serves as a protective factor in the development of PTSD.

The military also trains small unit leaders to assist in the prevention, reduction, identification, and treatment of combat trauma in soldiers serving in OIF and OEF. And on the home front a number of military programs have been established to better provide soldiers and their families with information pertaining to the impact and preventative

aspects of pre-deployment, deployment and post-deployment on psychological, social-emotional, and behavioral well-being. However, the accessibility of mental health support for families suffering the effects of PTSD in both the military and the VA system remains simply inadequate.

### *Barriers to Treatment*

Research tells us that the greater the severity of combat exposure, the greater the probability of developing chronic PTSD, with repeated trauma known to impair the development of higher level brain functioning. It also tells us that frequent periods of rest and replenishment, limited tour of duty, and an environment free of prolonged exposure can fight against combat-related trauma (DeFazio, 1978). Yet we continue to re-deploy an all-volunteer force with a frequency that is contributing to what many predict will be some of the highest rates of combat-related trauma in history. Data concerning delayed onset of trauma throughout the years indicates that long after American involvement in the wars in Iraq and Afghanistan cease, veterans will be seeking help for their symptoms.

Research also informs us that anyone can develop PTSD symptomatology given the right circumstances – no one single biomarker or predisposition can make people more likely to become combat stress casualties sooner than others. Yet many in our armed forces continue to treat those afflicted with the illness as lacking in strength of character and courage, creating a system whereby soldiers are fearful of seeking out much needed treatment due to possible repercussions. The stigma associated with combat-related trauma is one of the greatest barriers to treatment, if not, this author argues, a risk factor for chronic onset of symptoms due to delayed assistance.



Another barrier to treatment is the lack of trained combat-trauma professionals both at home and on the front lines. Prior to the First World War mental illness was treated by alienists, doctors who worked in asylums, or physicians who had an interest in psychology. Their expertise was questionable, their training random, and their motives suspicious in the base case. While initially WWII created a burgeoning interest in the diagnosis and treatment of trauma, and an increase in mental health professionals studying the phenomenon, it was not to last. Literature from WWII to date suggests that a shortage of adequately trained mental health professionals continues to be a problem (Koontz, 1947; Needles, 1946; APA, 2007), with many civilian clinicians lacking competence, confidence, and belief in utility of intervention (Salyers, Evans, Bond, & Meyer, 2004). With so few mental health professionals left to carry the burden of treatment intervention it is not surprising that the attrition rate among them is extremely high. Almost one-third of Army mental health personnel have reported high burnout, low motivation for their work, low morale, and a concern that these problems are impairing their abilities to provide adequate care to their clients (APA, 2007).

While the VA health care system works hard to provide mental health services to returning veterans seeking assistance, with staff truly dedicated to their recovery, a barrier to treatment which must be acknowledged is the amount of red tape veterans are required to undergo in order to receive services. For instance, if a veteran is seeking assistance for both a mental health concern, and a physical health complaint, they can spend days, weeks, and even months trying to access the necessary departments including screening, primary care, social work services, and mental health. Long waiting lists, limited clinic hours, and breakdowns in the referral process are cited as impediments for

soldiers and their families trying to access mental health services, with particular concern emanating around National Guard and Reserve personnel, who often live a long way from where support is centered (APA, 2007). If the veteran is seeking compensation for an illness related to time served on active duty, it can take up to a year to formalize and even then paperwork mistakes can force the whole process to begin anew. While some VA's appear to be working towards the elimination of bureaucracy, by creating clinics within their facilities that offer all services at one location, they still have a long ways to go and young veterans easily frustrated with the formalities will often seek assistance elsewhere.

An additional obstacle that mental health professionals face in the treatment of PTSD today is a lack of empirical research directing treatment for OIF and OEF veterans. Today's American active-duty soldiers are unlike any other combat cohort in our history with regards to gender, purpose, and cultural make-up. Both men and women serve on the front lines today, and while we are told that women do not directly engage in combat with the enemy, many would argue that their very presence in the war zone; driving convoys, flying helicopters and fighter jets, and taking on a myriad of duties which place them under enemy fire, is indeed, combat. In addition, the majority of our force is composed of Reserve and National Guard members – individuals who are accustomed to domestic training one weekend per month or two weeks per year in response to state or national disasters. Our soldiers today are an all-volunteer force whose primary purpose for joining the U.S. armed forces is to fund their education or receive job training. Some statistics have minority participation as high as 35 percent (Hedges, 2003), but the breakdown of differences reflective of race, gender, or sociocultural background with

regards to PTSD statistics is negligible, and the information we do have leaves us with more questions than answers.

For example, some military research states that Hispanic and African American soldiers are at higher risk to develop PTSD symptomatology, but additional research disputes such findings and states that once exposure to trauma is controlled for, the role of race in combat is no longer statistically significant. This same ambiguity surrounds research pertaining to female vs. male PTSD pathology, with civilian studies indicating that females are much more likely to develop the disorder but military studies contradictory in their findings. The vulnerability of minority groups to combat-related PTSD continues to be a debated issue, and additional research is called for which examines pre-existing conditions, psychosocial factors, and sociocultural influences as possible mediating factors in the development of this disorder.

Research and information pertaining to military family needs, as they relate to the 21<sup>st</sup> century, is also lacking. No longer is the nuclear family the “norm” within societal structure, with statistics to date suggesting that family’s consisting of an employed father and a stay-at-home mother make up only 3 percent of U.S. households (McGoldrick, 1998). While current data discussing the socio-economic, multi-cultural, and sexually-orientated make-up of our troops overseas is extremely difficult to obtain, treating families as though they stemmed from a typical white, middleclass nuclear structure would be extremely foolish on our part. Understanding the additional stress on relationships whereby partners are not recognized from a legal perspective or where divorce has isolated a parent from his/her children, on family members who are struggling with the symptoms of PTSD, is imperative on the part of the clinician.

Finally, much of the research used to further promote treatment in OIF and OEF combat veterans has been obtained through self-report in retrospective studies from the Vietnam era (including the NVVRS study, 1990). A problem in the methodology of retrospective studies is that memory changes over time, and recall of combat effects or hazards is influenced by psychological status, which can be influenced by feelings of physical and financial well-being. Follow-up studies, which cite significantly higher rates of PTSD symptomatology among combat veterans twenty years after they served on the front lines, must be examined with caution. Retrospective studies limit researcher's ability to draw conclusions due to concerns surrounding validity, reliability and methodology.

An additional reason as to why retrospective research conducted on Vietnam veterans is problematic pertains to the differences in warfare conducted in this region as compared to that fought in Vietnam. American volunteer soldiers in Iraq and Afghanistan are closely scrutinized by the media; are in constant communication with their families; are fighting an ambiguous enemy under urban guerilla combat conditions; and are deployed and redeployed at a much higher rate than soldiers from previous wars. These differences must serve to challenge the research community in our efforts to conduct randomized, controlled studies on this cohort so as to better understand their needs, vulnerabilities, and resiliencies in order to better guide treatment.

### *Moving Forward*

At a recent trauma conference which I was fortunate to attend in Houston, TX during May 2007, researchers from the Puget Sound VA medical center in Seattle, Washington presented a paper on *Innovations in Outreach and Health Care Service*

*Delivery for OIF/OEF Veterans*, detailing exactly what these veterans are seeking in terms of services. In their study consisting of 100 recently reintegrated OIF and OEF veterans, 42 percent of veterans reported that they accessed the VA for assistance with medications; 38 percent received counseling for mental and physical symptoms; and 32 percent were requesting assistance with employment, housing and finances (McFall, 2007).

For those seeking mental health services, clinicians discovered that 44 percent of the veterans preferred one-on-one individual counseling; 12 percent requested family or couples counseling; 10 percent preferred group therapy; and 10 percent wanted to receive counseling over the telephone (CBT). (These numbers are different from those provided by the U.S. Army and the National Guard, which both state the main reason for counseling referrals is for couples therapy (Sautter, 2007). Concerning counseling modalities, the McFall (2007) research noted that the majority of veterans wanted their therapy sessions to emphasize the development of learning skills which focused on calming and reducing stress or on practical methods for solving problems, with less than 33 percent of the veterans interested in talking about the combat experience. Therapists noted a high attrition rate among the veterans, and reported that 63 percent of their clients wanted to stay in touch with their counselors via email.

This research is very interesting in that it duplicates my experiences serving OIF and OEF veterans over the past year at the Houston, TX VAMC and the Houston, TX Veteran's Readjustment Center. I spent a great deal of time trying to create a processing or psychoeducational group for OIF and OEF veterans similar to that which has been successful among Vietnam combat veterans, but the percentage of veterans who were

interested in attending was minimal. They all preferred individual counseling, but the majority of veterans did not want to talk about their trauma experience[s]; instead preferring to direct treatment to the here and now with focus on practical matters. When veterans came in for treatment it was because they were *having difficulties with interpersonal relationships*, not necessarily because they wanted help with individual symptoms. In fact, many of the veterans I worked with did not necessarily think they had PTSD, or their symptoms were secondary to relational concerns, with few maintaining treatment over the 3 or 4 sessions necessary to conduct a full psychosocial assessment. As in the case of Paul (detailed in Chapter VII of this thesis), making a commitment to treatment even when symptoms are at times overwhelming and life threatening, appears to be extremely challenging for this cohort.

This ambivalence or denial from OIF and OEF veterans surrounding PTSD treatment is not surprising given the stigma associated with the diagnosis as well as the symptom manifestation of avoidant behavior. But the fact remains that the majority of individuals seeking mental health assistance at this time are doing so because they have developed the disorder (DOD, 2006) and their core symptoms of intrusive recollections, avoidance, and hypervigilance are negatively affecting their interpersonal relationships. Lack of efficacy surrounding preventative techniques such as debriefing and screening should serve to reinforce the duty we have, as Americans, to take care of our soldiers. If we cannot predict or prevent combat-related trauma with one hundred percent reliability, we have a moral duty to ensure that treatment, and all it implies, is employed.

One of the biggest challenges over the next several years, from this researcher's perspective, is going to be our ability, as clinicians, to quickly reach the OIF and OEF

cohort and create a safe therapeutic environment which makes veterans feel comfortable enough to participate in treatment. Time is of the essence as research tells us that rapid intervention is necessary, not only for symptom amelioration, but also to forestall possible formation of comorbid medical and or/psychiatric disorders and to prevent interpersonal or occupational impairment (Friedman, 2006). And while it can be argued that the creation of a safe therapeutic environment is one of the primary principles of intervention in the base case, it is especially imperative in the treatment of individuals suffering from combat-related PTSD whereby soldiers are victims one minute and perpetrators the next resulting in complex, unresolved emotional and behavioral issues which require a safety net before they can be exposed.

The historical way to go about achieving this goal would be through a systemic methodology which included biological treatment, psychotherapy, and social interventions. However, while this researcher strongly supports a multi-dimensional approach, I would argue that there is a compelling need to emphasize both family and couples therapy within the treatment paradigm. Experts at The National Center for PTSD recognize the necessity for increased intervention in the family arena and on their national website they state: ““effective treatment should involve family psychoeducation, support groups for both partners and veterans, concurrent individual treatment, and couple or family therapy”” (National Center for PTSD, p. 4, 2007). This is extremely relative given that both family and couples therapy within this population have effectively been ignored over the years despite knowledge that over 50 percent of soldiers currently serving in Iraq and Afghanistan are married, and approximately 700,000

children in the U.S. have at least one parent deployed overseas on active military duty (Monson, 2005; APA, 2007).

The psychological needs of OIF and OEF military personnel and their families are increasing, and certain familial risk factors contributing to higher levels of stress such as families with a history of problems, or families which have recently been moved to a new duty station, or who are experiencing their first deployment, have been identified (APA). When one member of a family system is exposed to war trauma, the family system becomes vulnerable to both readjustment strain and vicarious traumatization (Ford et al, 1993). Understanding that veterans with PTSD are twice as apt to be divorced, and more likely to be struggling with any combination of marital and family adjustment, sleeping patterns, parenting skills, social support, aggressive behaviors and domestic violence, adaptability and cohesion, and behavioral problems among their children (Dirkzwagger et al., 2005; Jordan et al., 1992; Sherman et al., 2006; Solomon, 1988), leaves us with little doubt as to what direction treatment needs to take.

While research informs us that the main cause of combat-related trauma is the trauma experience itself, we also recognize that one of the greatest post-trauma risk factors is lack of social support which, it can be argued, stems primarily from interpersonal and familial relationships. If we understand that the family system has the potential for both maintaining and eliminating PTSD (Stanton & Figley, 1978), and that the response of the family to the returning soldier suffering from this disorder can greatly influence the outcome of rehabilitation (Rabin & Nardi, 1992), emphasizing treatment intervention in this particular area makes practical sense. If a significant number of OIF and OEF veterans are seeking help for interpersonal relationships, which is what



emerging research suggests, then partners and family members may encourage veterans to seek out family and couples therapy; supporting their need for treatment. But with a recognized aversion to the therapeutic process these veterans are more determined than ever to base their participation on results, so we must be armed with sure-fire methods that will offer them exactly that.

Unfortunately, when it comes to family or couples-based treatment for PTSD, there are very few studies which have utilized a randomized, controlled methodology, making this goal all the more difficult. The only family intervention program in the VA system at this time is The Support and Family Education (SAFE) Program which has been modified (i.e., Operation Enduring Families) to address the specific needs of OEF and OIF populations suffering from PTSD (APA, 2007). Psychoeducation has been known to provide families with education on mental illness while increasing communication and problem solving skills (Sautter, 2007), and the SAFE program includes six goals: to teach caregivers about the symptoms and pathology of mental illness; to create a forum whereby family members have the opportunity to ask questions about psychiatric illnesses and treatment options; to reduce stigma surrounding mental illness; to publicize the different treatment options; to assist in the education of family members about early prevention; and to link caregivers with support services within the VA and the community at large (Sherman, 2003). But while the 18 session curriculum is non-diagnosis specific, only one session focuses primarily on the specific challenges surrounding PTSD in families (Sherman).

The SAFE program is still undergoing empirical evaluation and it may be some time before we understand its efficacy. Two questions are immediately called to mind

when considering usefulness with the OIF and OEF populations. Firstly, will a program that only devotes one session to the complex issues surrounding PTSD be useful to those suffering the unique challenges associated with the illness? And secondly, will a treatment paradigm designed to work only with caregivers be effective? At this stage these questions remain unanswered however, evidence suggests that family psychoeducation can produce significantly higher reductions in relapse and re-hospitalization rates, decreased costs of care, increases in patient participation in vocational activities, and positive outcomes for family members including improved morale (Dixon et al., 2001; Sherman, 2003).

It can also be argued that psychoeducation appears to carry less stigma than other clinical therapy models because of its emphasis on educational workshops which help to normalize symptoms, assist family members in understanding the illness, and encourage family members to come up with new ways of responding (Rabin & Nardi, 1992). This is extremely relevant when employing treatment interventions for military combat-related trauma, and might be a possible solution for the pervasive stereotyping which appears within this culture. I have also seen families and veterans dealing with PTSD become much more embracing of the therapeutic process when it is described as “coaching” and a metaphor of sports, or something equally personal, can be used as a re-frame. Additional recommendations to ease the stigma associated with combat-related trauma were made by the APA in their latest report detailing the psychological needs of military personnel (2007), and included the education of military leadership about the importance of mental health care and reducing stigma associated with such services. While such education certainly has its advantages, I believe that if soldiers had the opportunity to speak with, or

listen to, officers and other military mentors diagnosed with the illness who have sought treatment and had productive results, other soldiers would be less reluctant to seek treatment and less stigma would be associated with the diagnosis.

The psychoeducational component has also been noted as one of the benefits of couples therapy for both partners and veterans suffering from PTSD. In a study examining the efficacy of a psychoeducational program, which utilized cognitive behavioral and self-help techniques designed to address the needs of partners of Israeli PTSD veterans of the Lebanon war, researchers noted a 40 to 68 percent improvement across several areas of concern (Rabin & Nardi, 1992). Attitudes about military reserve duty as well as social relations at work, marital relations, parenthood, self-control, and problem solving ability all improved for a significant number of PTSD veterans nine months after partner participation in a one-month intensive program which concurred with veteran treatment (Solomon, Spiro, Shalev, Bleich, & Cooper, 1992). While no specific data is given pertaining to partner benefits, it stands to reason that if the greatest area of improvement among veterans was related to their interpersonal relationships, especially in the role of husband and father (but also with friends and at work), partners would benefit in a variety of manners.

Additional research examining therapeutic outcome of couples therapy with traumatized clients continues to emerge (Johnson, 2002; Monson, Guthrie, & Stevens, 2003) with findings suggesting improvements in veteran and partner symptomatology, as well as overall relationship satisfaction (Monson, Schnurr, Stevens, & Guthrie, 2004). Some treatment methods utilizing a psychodynamic component have proven successful in working with PTSD, including *emotionally based couples therapy* (EFT; Johnson, 1999),

which utilizes concepts of attachment theory, and *phase-oriented couples therapy* (Basham & Miehl, 2004) for survivors of childhood trauma. However, CBT couples therapy appears to have the most empirical support to date; targeting attitudes and beliefs that traumatized people have about relationships, and addressing issues about trust, power and control, self esteem, safety, and intimacy, with some figures indicating significant reductions in PTSD symptoms as rated independently by clinicians and partners (Monson et al., 2004; Sautter, 2007). Reduced marital and family stress, increased familial and spousal support, and a decrease in PTSD symptoms are all possible through the utilization of couple and family therapy, but efficacy of family intervention for combat-related trauma has yet to be established and further research is warranted as several questions remain unanswered.

For example, with our current understanding of childhood developmental stages, clinicians recognize that family treatment interventions for trauma be specifically designed to take into consideration a child's age, but more research is called for in examining this specific issue among combat-veterans and pre-deployment, deployment, and reintegration factors. Children's responses to deployment will differ depending on maturity, as Catherine Clancy, PhD, LCSW, Director of Clinical Social Work Training at the VAMC in Houston, TX has determined. In her presentation titled *The Impact of the Military Experience on Children* (2004), Clancy states that while infants less than 12 months may respond to a parent's deployment by refusing to eat, weight loss, and are at risk for apathy, toddlers (1 to 3 years) are more apt to approach the situation with sullen, tearful behavior which includes temper tantrums, and are at risk to develop sleep disturbances. Clancy states that preschoolers (3 to 6 years) may present with regressive

behaviors, signs of irritability, depression, aggression, and somatic complaints, and because of their age are in need of a more personalized explanation for their parent's deployment. School age children may become irritable and aggressive leading up to the assignment, and teenagers (13 to 18 years) may present with signs of irritability, sadness, rebelliousness, and other destructive behaviors. Clancy's research states that post-deployment and reintegration issues will also be experienced developmentally; confirming the need for effective family treatment interventions for combat-related trauma to reflect children's age-related abilities and developmental capacities. But with the dearth of family programs available within the VA system, the question of whether or not children are receiving the help they need remains unanswered as research in this area is difficult to come by.

Another consideration for family intervention must pertain to the socio-economic and cultural makeup of the family impacted by PTSD, which has warranted little research over the years. As authors Almeida, Woods, Messineo and Font (1998) state in their overview of a cultural context model, which considers issues of race, gender, class, and sexual orientation to be core components of family intervention:

Culture pertains not only to customs, values, family patterns and religious beliefs, but also to the social and political forces that have shaped family life over time. A woman who...receives a diagnosis of PTSD is also a member of a culture, a family, a community, and a workplace. We not only treat the PTSD, which is only a fragment of her identity, but also address her experiences as a woman of a particular race, religion, and so on. (p. 414, 417)

Pre-morbid, morbid, and post-morbid factors all come into play when an individual comes face to face with a traumatic experience during war. While research pertaining to minority predisposition to combat-related PTSD pathology is unclear, as clinicians we must consider the role that socio-cultural influences such as stoicism, normalization of stress, fatalism, and racial/ethnic discrimination may have in every individual we treat for this disorder; much like we would consider sociocultural factors in treating any other mental illness.

At the end of the day the only sure way of eliminating combat-related PTSD would be to end war as we know it but, as we have little control over this particular decision making process, it makes sense that we concentrate efforts on empirical research and treatment interventions that we know will significantly impact recovery. There is no silver bullet for the treatment of combat-related PTSD which means there is not one specific intervention understood to successfully treat each and every case. Individual differences negate such an approach; albeit there is a general understanding that individual treatment for the disorder include stabilization, de-conditioning, re-structuring, and the re-establishment of personal integrity and interpersonal value. While this researcher is encouraging a stronger integration of family and couples therapy within the treatment paradigm, not every veteran has a family therefore an in-depth assessment, which includes clinical diagnostic interviews, psychological testing (i.e., cognition, memory, attention, information processing), and in some cases neurobiological testing (i.e., reactivity measures), is required to determine individual needs. All treatment interventions for this disorder should take into consideration a multi-systemic biopsychosocial approach that includes psychopharmacology, psychoeducation,

psychosocial rehabilitation, and individual and group psychotherapy models. But in those cases where family support or lack there-of has become a mitigating factor in the pathology of this illness, or has the potential to do so, history and emerging research suggests to this researcher that clinicians must concentrate more fully on the family, or couple, dynamic.

While the Smith College School for Social Work continues to support its ties to the military mental health community in a variety of ways, and stays abreast of combat-related trauma treatment intervention through faculty, student, and alumni research, there is more that can be done. As this thesis has demonstrated, military culture is unique in its makeup whereby soldiers are trained to think of themselves as an indispensable, contributing member of their unit whose success is based on their leadership abilities as well as their physical courage and mental toughness.

Group cohesion and unit success are highly valued, and the concepts of “tough guy,” “macho,” and “work hard/play hard” are stressed from the very start of their basic training and throughout their active duty service. Many active duty families live together in a military community where competence and heroism is rewarded through the military ritual of ceremonies, awards and decorations. These are proud families who are constantly reminded of the service their soldiers provide and the fragility that exists between life and death. Any vulnerability is experienced as a threat to the military culture which must present itself as resilient and indestructible in order to achieve its primary goal during combat situations – to win.

Understanding this military culture and utilizing constructs unique to its structure in the treatment of combat-related trauma is imperative if we wish to successfully treat

this illness. In several areas of this thesis the differences between combat-related trauma and civilian trauma have been identified and in Chapter VII, which was devoted entirely to the Smith College School for Social Work, it was recommended that individual course instruction on combat-related trauma be implemented because of these differences. I also believe that additional focus on the unique family and couple issues found within the realm of combat-related PTSD, within the appropriate treatment modalities, would also be extremely beneficial. In addition, while a psychodynamic approach is highly valuable as treatment unfolds, and provides clinicians an indispensable framework from which to function, I believe an argument for short-term cognitive behavioral therapies and psychoeducational approaches has been adequately presented within this chapter, and must also be considered with increased course availability for students interested in these protocols.

Supplementary education on secondary traumatization as well as countertransference, transference, and parallel processing issues as they apply specifically to working with traumatized clients is also necessary. This education does not need to focus specifically on combat-related PTSD but an understanding of the complex interpersonal aspects of military trauma (i.e., guilt, shame, helplessness, exhilaration), which can be played out within the therapeutic dyad, need to be addressed. Veterans suffering from combat-related PTSD undergo intense emotional reactions and their narratives can be horrifically depicted. The way in which a clinician responds to a soldier's portrayal of trauma can have constructive or adverse effects on the therapeutic process with successful interventions involving sharing, honesty, mutual trust and authentication (Dewey, 2004).



Finally, the necessity of client empowerment in the treatment of combat-related trauma, or any other form of mental illness, is one which the Smith graduate school emphasizes within its biopsychosocial perspective, and one which must continue in order to facilitate healing and acceptance of this illness. Arthur Egen Dorf writes about the concept of empowerment in his book *Healing from the War: Trauma and Transformation after Vietnam* (1985):

What empowers? Nothing we do or say, if we regard empowerment as work that must be done or a place to get to, as if the other person were not already able and whole. What, then is there to do? Essentially nothing. There is nothing more empowering than simply seeing others as already equipped to handle their lives. And when they get that that way of seeing is genuine and real for us, and not merely a set of glib assertions, whatever we say or do naturally communicates, that is, creates a relationship in which the other is taken as a fully enfranchised partner in living. (p. 238)

#### *Strengths and Limitations*

From a research perspective the most obvious limitation of this study is the lack of newly conducted qualitative or quantitative exploration. And while this researcher attempted to incorporate empirically tested methodologies within the paper's content, the number of retrospective studies utilized and/or researched, which relied upon self report measures, were significant. In addition, research conclusions presented here are contingent, as are conclusions within historical studies in general, with no "last word" per se that can be implied. Finally, limitations pertaining to the objectivity, or lack thereof, of

the individual performing the research must be acknowledged. While this researcher attempted to present the literature on combat-related trauma in an objective, historical, context, personal belief systems and sociocultural factors may have influenced outcome. Conclusions drawn from historical research are influenced by the researcher's ability to perform a critical and objective interrogation of the evidence. However, literature employed may be specifically chosen in order to support a particular hypothesis which in this case examined combat-related trauma through a historical biopsychosocial outlook.

On the other hand, the strengths of this study are numerous. Etiology, pathology, and treatment outcomes of combat-related trauma from WWI through OIF and OEF have been meticulously examined with over 250 references used to draw conclusions. The historical methodology allowed the researcher to compare and contrast the phenomenon of trauma as it has evolved throughout the century, and significant data was garnered from both empirical and historical sources to further understanding. In particular, a biopsychosocial lens was used so that a complete, multi-systemic picture could be developed and presented. This lens was unique in that it examined the curriculum, instruction, and theoretical approach to trauma as provided by the Smith College School for Social Work, and considered the role of the psychiatric or clinical social worker, throughout the process. Finally, content reflected the diversity of soldiers who have continuously served in our armed forces and the sacrifices made by all as evidenced by the personal narratives woven throughout.

As time marches on so do new prescriptions for war trauma. The Madigan Army Medical Center in Tacoma, Washington and researchers at the University of Southern

California are using virtual reality techniques to re-expose soldiers to the sources of their traumatic experiences in a modern-day version of desensitization. Various VA medical centers across the country are experimenting with motivational interviewing, as well as cognitive processing therapy, as possible treatment solutions. Researchers in South Carolina have received FDA approval for the examination of the benefits of MDMA (Ecstasy) to assist in the breaking down of psychological barriers which impede successful psychotherapy. And Propranolol, a non-selective beta-adrenergic receptor jamming agent, is being examined at Harvard Medical School for its potential use in blocking traumatic memories in soldiers suffering from PTSD. While research will no doubt continue to rapidly unfold in the treatment of this illness, it is imperative that clinicians base treatment decisions not only on emerging data but on historical implications as well. Only then will they begin to fully understand how trauma shapes both the inner world and interpersonal relationships of our veterans, and further their clinical capabilities in responding to the complexity of circumstances to which these soldiers have been exposed.

## Soldier's Creed

I am an American soldier. I am a Warrior and a member of a team.

I serve the people of the United States and live the Army Values.

I will always place the mission first. I will never accept defeat.

I will never quit. I will never leave a fallen comrade.

I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. I always maintain my arms, my equipment and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American Soldier.

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