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EXPERIENCING AND COPING WITH TRAUMA IN WARFARE AND MILITARY CONFLICTS[†]

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The article investigates the methods of treatment of post-traumatic stress disorders in war and military conflicts. In modern psychiatry and clinical psychology, an externally conditioned mental disorder has been introduced - a kind of scientific acceptance that has not previously been used in the classification systems of mental disorders. Particular attention is paid to the new diagnostic manual ICD-11-CM (International Classification of Diseases, 11 Revision, Clinical Modification), which comes into force on 01.01.2022, which brings great innovations, especially in the diagnosis of injuries. It will also affect possible medical procedures and therapeutic interventions. Therefore, in the next few years there will be a major change in the paradigm of treatment. It is noted that an expert survey of the International Society for Traumatic Stress Research on Best Practices in the Treatment of Complex Post-Traumatic Stress, which interviewed 50 international experts, showed that consistent treatment is preferred, with a focus on coping skills (including emotional interventions) and memory trauma (using various therapeutic techniques). Despite the existence of a very small number of randomized therapeutic trials, a basic consensus on the most important therapeutic goals has been documented.

Keywords: *violence, post-traumatic stress disorder, effectiveness of medical care, ICD-11-CM, health policy, personality disorders*.

Introduction

Experiencing and coping with trauma has been part of the consequences of military conflicts since time began. Psychological treatment of the phenomenon, on the other hand, is a very new matter, as psychology itself is little more than 150 years old.

The treatment of stress and trauma is also strongly dependent on the new diagnostic manuals. Since 01.01.2022, the ICD-11 is now coming into power, which brings with it extensive innovations, especially in trauma diagnostics. The possible treatment procedures and therapy interventions are also affected by this. There will therefore be a major paradigm shift in the next few years, so it is worth taking a look at it as an introduction.

Origins and development of the classifications regarding stress and trauma

Origins of the classifications of causes of death and diseases date back to the 18th century (Sauvages' Nosologia Methodica, Linnaeus' Genera Morborum, Cullen's Synopsis Nosologiae Methodicae). Sir George Knibbs, the eminent Australian statistician, credited François Bossier de Lacroix (1706-1777), better known as Sauvages, with the first attempt to classify diseases systematically (10). Sauvages' comprehensive treatise was published under the title Nosologia methodica. A contemporary of Sauvages was the great methodologist Linnaeus (1707-1778), one of whose treatises was entitled Genera morborum. At the beginning of the 19th century, the

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classification of disease in most general use was one by William Cullen (1710-1790), of Edinburgh, which was published in 1785 under the title Synopsis nosologiae methodicae. The International Classification of Diseases (ICD) is the world's standard tool to capture mortality and morbidity data.

The ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used by physicians, psychologists and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care (WHO, International Statistical Classification, 2021). The 10-10 contains a lot of advantages. The benefits of ICD-10 are for example

- Measuring the quality, safety and efficacy of care.
- Designing payment systems and processing claims for reimbursement.
- Conducting research, epidemiological studies, and clinical trials.
- Setting health policy.
- Operational and strategic planning and designing healthcare delivery systems

The latest revision of the ICD, ICD-11, was adopted by the 72nd World Health Assembly in 2019 and came into effect on 1st January 2022. The ICD-11 integrates the different modifications and adaptations of ICD-10, reflects the current global clinical needs, ensures long-term comparability of the data, and provides standardized solutions for the digital era we all live in.

Posttraumatic stress disorder – an new view on an old symptom regarding the ICD-11

The introduction of the diagnosis of posttraumatic stress disorder (PTSD) according to Maercker et al. (2021) was a major milestone for the mental health field according to Maercker et al (2021). An externally caused mental disorder was introduced into the state of the art of psychiatry and clinical psychology – a kind of scientific recognition, which has never been seen before in classification systems of mental disorders. The introduction of the diagnosis according to Maercker et al. (2021) followed a political negotiation process in U.S. psychiatry, in which scientist-practitioners played an important role, with Vietnam veterans on the one hand and the women's rights movement on the other hand as advocates (Young, 1997).

The Vietnam War for example had ended in 1975, and American Veterans Administration Hospitals were faced with large numbers of traumatized veterans they had to care for according to Maercker et al. (2021). The women's rights movement could make its voice heard for traumatized women as victims of domestic or sexualized violence (Maercker, 2021).

Just as important as the political advocacy, according to Maercker et al., was the further development of psychopathology or the investigation of psychological stress consequences at that time. Mardi J. Horowitz had presented the concept of 'stress response syndromes', which turned out to gain wide attention through clinically precise descriptions and a psychodynamic-cognitive model and was accompanied by a large empirical research program. He according to Maercker et al. (2021) described prototypically the psychological consequences of severe traffic accidents and applied this to wartime experiences, concentration camp imprisonment, rape, and life-threatening medical conditions. As core symptom groups, he depicted intrusions and avoidance, followed by negative cognitive and mood changes such as guilt and shame. This research-based and operationalized approach laid the scientific foundation for PTSD as a new disease entity (Horowitz, 1976).

Enduring personality change after catastrophic experience

According to Maercker et al. (2021) the PTSD diagnosis was in 1990 first officially recognized in the International Classification of Diseases, 10th version (ICD-10: Word Health Organization, 1990). In addition to PTSD, the chapter on 'Disorders of adult personality and behaviour' included the diagnosis 'Enduring personality change after catastrophic experience' (EPCACE: ICD-10 code F62.0). This disorder concept was based on the diagnostic proposal of a 'concentration camp syndrome' by Leo Eitinger (1961), as Maercker et al. underline. However, this narrower model was abandoned in favor of a more

general formulation. EPCACE was symptomatically defined in the ICD-10 research criteria by a persistent hostile or suspicious attitude towards the world, social withdrawal, a persistent feeling of emptiness or hopelessness, but not with the full core symptoms of PTSD.

It is important to note according to Maercker et al. (2021) that in the previous diagnostic systems, PTSD automatically transitioned into a persisting personality disorder after two years. EPCACE had, as Maercker et al. (2021) underline, received minimal attention in the expert literature. One particular criticism concerned the lack of specificity of its criteria and the difficulty of using broadly defined sets of criteria in practice (Beltran, Silove, & Llewellyn, 2009). Not a single study or case report was devoted to this disorder in connection with childhood abuse or sexual violence.

To solve the basic psychometric validity problems of the assessments for complex presentations of trauma sequelae, Briere, Elliott, Harris & Cotman (2009) developed the Trauma Symptom Inventory as a self-report according to Maercker et al. (2021). The Trauma Symptom Inventory contained broad areas (ten symptom clusters and so-called validation scales) of possible trauma consequences and was examined in many samples of child abuse/maltreatment or sexual violence survivors. The results obtained with this instrument using elaborate methodology were used to formulate the ICD-11 definition of Complex PTSD. In particular according to Maercker et al. (2021), these data showed that patients with complex trauma episodes not only experienced affective, relationship, and self-image problems, but also showed the core symptoms of 'classic' PTSD, i.e. intrusions, avoidance, and hyperreactivity ([e.g. Krammer, Simmen-Janevska & Maercker, 2013).

A further milestone along the way to the current CPTSD formulation was according to Maercker et al. (2021) the expert survey of the International Society for Traumatic Stress Studies on best practice treatment of Complex PTSD, in which 50 international experts were interviewed (Cloitre et al., 2011). The results showed according to Maercker et al. (2021) a preference for sequential treatment, a primary focus on coping skills (including emotion regulation interventions), and on the narration of trauma memory (using various therapeutic techniques). Thus, according to Maercker et al. (2021) despite the existence of very few randomized therapy studies, a basic consensus on the most important therapeutic goals was documented.

The WHO had set the goal to increase the clinical utility of all diagnoses in the new ICD-11 (published in 2018) according to Maercker et al. (2021), which was mainly to be achieved by the lowest possible number of core symptoms. This should enable clinicians in all parts of the world to use the diagnosis as easily as possible. In addition, new diagnoses should only be introduced if there is sufficient clinical knowledge for specific therapies. The working group for diagnoses in the area of 'Specific Stress-related Disorders', which was composed of members from all continents and various NGOs, decided that the PTSD diagnosis established since 1980 should be complemented by a sibling diagnosis, the complex PTSD diagnosis. This replaces the previous EPCACE diagnosis.

The core symptoms of classical PTSD according to Maercker et al. (2021) have been narrowed down and are now: Re-experience in the present, avoidance of traumatic reminders, and a sense of current threat. These three symptom groups are also part of the CPTSD diagnosis. In CPTSD there are three additional symptom groups that can be summarized as disturbances in self-organization: Emotion regulation difficulties (e.g., problems calming down), relationship difficulties (e.g., avoidance of relationships) and negative self-concept (e.g., beliefs about the self as a failure) (Maercker et al., 2013).

The work of the WHO work group included conducting several clinical field studies on the new concepts according to Maercker et al. (2021). First, validity aspects of the diagnoses were investigated in comparison to the previous diagnoses in an international case-controlled field study. It was found that the new CPTSD diagnosis with 83% inter-rater agreement was more correctly assessed by clinicians than EPCACE with 65% inter-rater agreement (Keeley et al., 2016). Subsequently, field studies in 13 countries with 340 clinicians and 1806 patients were conducted to verify the agreement of the

evaluators. Here according to Maercker et al. (2021), the CPTSD diagnosis had a mean kappa = .56 (Reed et al., 2018) – which led to a further optimization of the narrative definition in the WHO Clinical Guidelines. As a result, in a subsequent web-based clinical study it was in the top group of several diagnoses for correct diagnosis (percentage of diagnostic accuracy) (Gaebel et al., 2020).

Of course, at all stages of the development of the CPTSD diagnosis in ICD-11, clinical differentiation from borderline personality disorder (BPD) played a role according to Maercker et al. (2021). In the meantime, some research exists that provides information on this distinction and point to the treatment implications of these differences, e.g. (Cloitre, 2020). While the self-image of patients with BPD changes abruptly between exaggeratedly negative and exaggeratedly positive self-perceptions, in CPTSD it remains persistently negative. In BPD, the relationship difficulties show up with rapid relationship initiation and an up and down of idealization and devaluation of the partners, while CPTSD patients avoid or break off relationships in times of strong general stress. The two diagnoses also differ in terms of suicidal tendencies: In BPD, these suicidal tendencies occur together with self-harming behaviour and thus become a primary therapeutic goal, while in CPTSD the frequency and intensity of these problems is lower according to Maercker et al. (2021).

In the meantime according to Maercker et al. (2021), an international consortium of researchers and clinicians has developed a measurement tool – both a self-rating version and a clinician-assessment version—that assesses diagnosis and severity (www.traumameasuresglobal.com). Validated versions of the self-rating version are already available in different languages, while the validation of the clinician assessment in different languages is still in progress (see above website).

Since the publication of the beta version of the CPTSD definition by the ICD-11 working group (Maercker et al., 2013), there has been a boom in research on this new diagnosis, especially in diagnostic and prevalence research according to Maercker et al. (2021). A PubMed® search in titles (search terms: [complex post-traumatic stress disorder or complex PTSD or CPTSD]) resulted in nine publications for 2014, which increased over all years (e.g. Keeley et al., 2016). Reviews are available on the validity aspects of the CPTSD diagnosis – also in distinction to classic PTSD (Brewin et al., 2017) and evidence-based treatment options. It is obvious that research into the bio-psycho-social-cultural conditions of the disorder should be intensified, and this will certainly happen more intensively in the coming years according to Karatzias et al. (2019).

Trauma therapy in Austria

Austria had a lot of psychologically war-disabled people during the First and Second World Wars. In the following years, Austria participated in international missions within the framework of the UN and other cooperations. As a result, the number of classical mental illnesses in this sector has decreased. On the other hand, approaches in the field of prevention and therapy have continued to be developed. New strategies were also developed in the context of the refugee crises. It was precisely from this area that Austria was particularly confronted with a large number of demands.

There is no classical trauma therapy or specialisation in Austria. The therapy approaches are mainly to be seen eclectically. A popular variant is the completing of a therapy training. In Austria, more than in any other country in Europe, there are around 22 different recognised therapeutic schools. This has to do with the historical development of Sigmund Freud in Austria.

In recent years, systemic hypnotherapy approaches in particular have gained a lot of attention. However, the trainings in this sector are not subject to any state regulation, but are occasionally of very different quality. To counteract this, the Milton Erikson schools have established a minimum standard of training and do not offer fast-track trainings, but rather professionally based seminars.

Another problem is that traumatised soldiers from Austria, e.g. from Golan missions, etc., also become addicted to drugs. This shows great analogies with the Vietnam War of the 1960s and 1970s, when 10% of the GI's became addicted to heroin. Long-term counselling is offered which is financed by the state.

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ПЕРЕЖИВАННЯ ТА ЯК ВПОРАТИСЯ З ТРАВМОЮ НА ВІЙНІ ТА У ВІЙСЬКОВИХ КОНФЛІКТАХ

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У статті досліджуються методи лікування посттравматичних стресових розладів на війні та у військових конфліктах. У сучасній психіатрії та клінічній психології введено зовнішньо обумовлений психічний розлад – своєрідне наукове прийняття, яке ще не було раніше застосовано в системах класифікації психічних розладів. Особливу увагу приділяється новому діагностичному посібнику ICD-11-CM (International Classification of Diseases, 11 Revision, Clinical Modification), який вступає в дію з 01.01.2022, що приносить з собою великі інновації, особливо в діагностиці травм. Це також вплине на можливі лікувальні процедури та терапевтичні втручання. Тому в найближчі кілька років відбудеться серйозна зміна парадигми лікування. Відзначається, що експертне опитування Міжнародного товариства досліджень травматичного стресу щодо найкращої практики лікування комплексного посттравматичного стресу, показало що перевага віддається послідовному лікуванню, з основним акцентом на навичках подолання (включаючи втручання з регулювання емоцій) і на розповідях про травму пам'яті (з використанням різних терапевтичних прийомів). Незважаючи на існування дуже малої кількості рандомізованих терапевтичних досліджень, було задокументовано основний консенсус щодо найважливіших терапевтичних цілей.

Ключові слова: *насильство, посттравматичний стресовий розлад, ефективність медичної допомоги, ICD-11-CM, політика здоров'я, розлади особистості.*

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