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Combat Stress The Commonwealth Experience

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This article is the text of Copp's presentation to the 2007 Security and Defence Forum Conference in Ottawa. Combat Stress: The Commonwealth Experience *is in press.*

Abstract: Psychiatrists and psychologists have sought to diagnose and treat war-related trauma by applying the intellectual and social constructs current in their profession. Whether derived from Freudian and other psycho-dynamic theories or physiological approaches, the concepts employed have rarely been evidence-based. This article examines the question of combat stress from a historical perspective and argues that an evidence-based framework for decision-making about operational stress injuries is essential.

This brief presentation is derived from work I am undertaking with my colleague Mark Humphries for the Canadian Defence Academy. We are completing an edited book of readings titled *Combat Stress: The Commonwealth Experience*. The book will offer examples of the ways in which psychiatrists and psychologists have sought to understand the origin, prevention and treatment of combat stress and its aftermath. The purpose of the book is to provide historical perspective on the ideas presented by contemporary specialists in military history.

Currently the Canadian Forces and Veterans Affairs Canada (VAC) use the term operational stress injuries, rather than combat stress, critical incident stress, battle shock, combat fatigue, battle exhaustion, anxiety neurosis, or shell shock but all these terms are attempts to describe similar phenomena. My own favourite is "Not Yet Diagnosed (Nervous)."

Since the conference is focused on post-Afghanistan foreign and defence policy we can begin with the relatively non-controversial statement that the best available evidence suggests that operational stress injuries, including post-traumatic stress disorder (PTSD), increase with exposure to combat and we may therefore expect that a significant percentage of those troops deployed to Kandahar will experience combat stress in Afghanistan while a much larger number will subsequently develop symptoms of stress-related illness including depression and PTSD.[1] Current estimates of the likely numbers should be treated with caution as much depends on definitions, access to health care and the culture surrounding those who respond to questionnaires. Without firm numbers on the incidence of PTSD in the general population, a control group of age-categorized civilians and the military in general, quoting a percentage figure for PTSD among previously deployed troops is not very helpful.

This deliberately general statement requires an explanation which is part autobiographical. I first became interested in this subject while researching the operational and tactical history of the Canadian Army in the Second World War. Historians had paid little attention to the effects of what was then called battle exhaustion even though up to 25 percent of battlefield casualties were evacuated to psychiatric centres. Together with Bill McAndrew, we published *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army 1939-1945* in 1990.[2] The book was well received, particularly in the United States and the United Kingdom, and I began work on a much larger project designed to analyze developments after 1945.

During the research for *Battle Exhaustion* I interviewed many of the Canadian psychiatrists who had played key roles in the wartime army and postwar veterans' re-establishment programs. I was especially influenced by three pragmatic Canadian doctors, J.C. Richardson, Burdett McNeel and Travis Dancey who had served with distinction during and after the war. Their influence is evident in my previous publications[3] and this presentation.

During the 1990s I began similar interviews with American and especially British psychiatrists including the Director of British Army Psychiatry, Brigadier Peter Abraham. It was soon evident that

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the scope of the proposed project would require external funding and time release from the classroom but the guardians of the medical history field were not impressed. An historian without credentials in medicine, psychiatry or psychology was not acceptable as the principal investigator for such a project so I returned to the study of operational matters while maintaining an interest in the area.

I tell this story because the literature on combat stress and PTSD is largely the work of professional psychiatrists and psychologists who are pursuing specific methodological or research agendas. There is nothing surprising in this but since the research agendas frequently conflict it is important to determine which studies are evidence-based. For example my files include material on a wide range of treatments for PTSD including craniosacral therapy, yoga, a "virtual Iraq" simulation using a modified X-box "Full Spectrum Warrior" game and many others. Positive results reported are largely due to the placebo effect and are reminiscent of earlier enthusiasm for faradism (the employment of an electrically-charged wire brush) insulin sub-coma therapy, LSD, hypnosis, de-patterning and many other abandoned treatment methods. Perhaps an historian's overview can be of some value.

Let us begin with a thesis statement. The argument of this paper is that throughout the 20th and 21st centuries psychiatrists and psychologists have sought to diagnose and treat war-related trauma by applying the intellectual and social constructs current in their profession. Whether derived from Freudian and other psycho-dynamic theories or physiological approaches, the concepts employed have rarely been evidence-based. Anecdotes and famous case studies have underpinned most psychiatric research.

One of the major sources of confusion in current discussions of operational stress injuries is the problem of distinguishing between acute stress casualties on the battlefield and delayed responses including PTSD. In the First and Second World Wars, casualty clearing stations were overwhelmed with individuals who had broken down under intense combat conditions. During the Great War many if not most of these breakdowns were characterized by "hysteria," including paralysis of limbs, speech or other functions. Such reactions largely disappeared in the Second World War to be replaced by withdrawal, trembling and pronounced startle reactions. Individuals appear to have unconsciously displayed symptoms of sufficient intensity to achieve primary gain – immediate relief from the stressful situation in ways acceptable to psychiatrists of the era.[4]

During the Korean and especially the Vietnam War the incidence of acute reactions to combat declined dramatically. Many explanations for this remarkable situation have been put forward with some consensus that the one-year rotation policy was critical in maintaining the soldiers will to keep it together for the balance of his tour.

During the period when I was more actively involved in this research British military psychiatrists dealing with the Falklands, Northern Ireland and Balkan deployments were confident that the selection, training and treatment methods

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The stress of battle clearly shows on the face of a Canadian infantryman as he has his physical wounds attended to during the harsh fighting in the Scheldt Estuary, October 1944.

employed in the British Army had reduced "battleshock" to a minimum. Furthermore in the words of Brigadier Abraham, who took me to task in the *British Army Review* for suggesting otherwise, "exhaustion or shock need only be temporary and it is up to everyone from junior commanders to doctors to see that it is so."[5]

Unfortunately what really appears to have happened is that a different way of manifesting the symptoms of stress similar to those which had lead to the diagnosis of Post-Vietnam Syndrome and eventually PTSD had emerged in the United Kingdom. The British Ministry of Defence (MOD) was quite unprepared for the situation having insisted that through the application of the classic principles of forward psychiatry – proximity, immediacy and expectancy – the rate of full recovery would be very high. If a chronic neurosis developed it was due to pre-enlistment genetic or developmental factors. PTSD was viewed as a result of the particular circumstances of the Vietnam War, a conscript army and a peculiarly American reaction to the conflict.

When more than 2,000 British veterans joined a class action suit originally brought by survivors of incidents in the Falklands, the High Court of England and Wales accepted the explanations of the MOD and denied the claimants' argument that the army had failed to provide adequate measures of prevention, detection and treatment for PTSD.[6] The High Court judge, Mr. Justice Owens, did recognize that by 2003 when his judgment was rendered, PTSD had become widely recognized placing a new burden on the MOD but, he noted, this was not the case in 1980. He also recognized that:

> the ultimate function of the military is to fight and win in battle. This meant that there will always be a necessary culture of toughness. It is a culture of mutual dependence in which the interests of the individual are subordinated to those of the organization.[7]

Mr. Justice Owens also dismissed claims that the screening, pre-deployment and post-deployment briefings in relation to stress were inadequate. There is, he wrote, "no conclusive or empirical evidence" that screening or such briefings are effective,[8] a view now widely shared.

The High Court case is of considerable interest because Mr. Justice Owens listened to a complex debate sifting the evidence with care. He held, correctly, that while there were many ideas and opinions about stress-related injuries there was remarkably little credible research available to support the various arguments. The one area where he was reasonably confident about the evidence of efficacy was with regard to current treatment options for PTSD. He agreed that Cognitive Behaviour Therapy (CBT) alone or in combination with antidepressant drugs such as selective serotonin reuptake inhibitors (SSRIs) appeared to be effective. It was, however, apparent that CBT, as presently understood, was not available until the late 1990s.[9]

We may now return to the Canadian scene where a similar pattern may be discerned. After a lengthy period of denial, uncertainty and the ad hoc provision of stress-related pensions National Defence and VAC moved towards a measured approach which may yield better results. The VAC website for "clients" currently offers the following statement on mental health support for veterans:

> Given the complexity of today's military operations, many members of the Canadian Forces (CF) may return home with a variety of operational stress injuries, such as post traumatic stress disorder (PTSD) and depression. We now have in place mental health programs, services and policies that offer you and your family continuous mental health support. These services include early intervention and treatment, relevant and helpful information, rehabilitation and on-going care.[10]

Operational Stress and Support Centres opened in Esquimalt, Edmonton, Ottawa, Valcartier and Halifax in 1999 providing a range of counseling and therapy.

Veterans Affairs Canada also shares the view that cognitive behavioural therapy, which employs a "time-limited, present-oriented approach to psychotherapy and teaches patients the cognitive and behavioural competencies needed to function adaptively,"[11] provides the best results. Most importantly the Health Services Directorate of DND is currently engaged in a number of well constructed research studies which will offer policy makers and practitioners a much more substantial evidence-based framework for decision-making about operational stress injuries.

One major area of continuing concern is what was known as "the pension question." After the First World War, despite contrary evidence from psychiatrists, Canada, in common with other countries, began to provide Great War veterans with pensions for "shell shock and neurosis." By 1927 9,000 veterans were receiving modest sums and thousands more were seeking them. In our book we will offer several examples of the widespread debate over the problem of secondary gain – the maintenance of neurotic symptoms – including Dr. Travis Dancey's 1950 paper to the American Psychiatric Association titled "Treatment in the Absence of Pensioning for Psychoneurotic Veterans."[12]

Will it be possible to deliver CBT, which requires multiple sessions of group therapy with psychiatrists able to prescribe SSRIs, or will the hundreds of regular and reservist veterans presenting symptoms join the large numbers of British, American, Anzac and Canadian veterans receiving pensions for PTSD. The challenge confronting the Health Services Directorate and VAC should not be underestimated.

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We know very little about the causation of acute or delayed stress injuries. Stephen O'Brien, the author of *Traumatic Events and Mental Health* (Cambridge, 1998) served as an army psychiatrist in the Falklands. He distills the major challenge in understanding combat stress reactions:

> If three men are in an armoured vehicle and the vehicle next to them bursts into flame, one may feel that witnessing death up close is terrible. A second may see it as an indication that he too may be killed, heightening his fear. The third may see it as a lucky escape and proof of personal invincibility.

The stressor is the same, but each individual responds differently. The second individual may exhibit combat stress reaction (CSR) symptoms but may not and we have no way of predicting whether any of the three will develop PTSD. There is no reliable evidence that pre- or post-deployment briefing and de-briefing focused on operational stress injuries is effective and some evidence suggests that it may in fact be harmful.

Since the completion of the Human Genome Project in 2003, the major thrust of research on stress-related injuries has been the study of inherited liability for PTSD, but nothing conclusive is yet known. The treatment issue is almost as cloudy. The evidence that forward treatment reduces the severity of stress reaction and allows a much greater proportion of men to return to their units and stay well is shaky and in the absence of follow-up studies should be treated with caution. Treatment of delayed reactions inducing PTSD by CBT and drugs has shown promise but such therapy may be negated by the possibility of disability pensions for PTSD.

Few military commanders can be expected to stay abreast of psychiatric research but they should at a minimum be aware that current ideas on treatment and prevention are based on explanatory models that may lack empirical validity. Officers charged with the command of troops in stressful situations may find themselves required to work within an officially approved medical-administrative framework but they should resist those parts of the model which promote the view that CSR and PTSD are normal. They have the responsibility to ensure that the men and women under their command have confidence in the mission and in its leadership at all levels. They must strive to create an atmosphere in which expectancy means the expectation of courageous, disciplined, soldierly behavior rather than potentially disabling physical, cognitive and emotional disturbance. I am not advocating that we return to an age when acute and delayed stress reactions were regarded as evidence of a lack of masculine fortitude but telling soldiers that traumatic stress can be seen as part of a normal human response to intense experiences may actually be contributing to the problem. If a person is told that a certain outcome is normal, for some people it may be maladaptive for them *not* to embrace it. If commanders keep this in mind, they will not only contribute to the success of their mission, but also to the well-being of their soldiers.[13]

Notes

1. Matthew S. Friedmans et al, *Post Traumatic Stress: An Overview*, Veterans Affairs Canada, <www.vac-acc.gc.ca/clients/sub.cfm?source=mental-health/support/factsshc> (accessed 30 September 2009). For the ongoing debate over the numbers of Vietnam PTSD Numbers" *Medline Plus*, www.nlm.nih.gov/medlineplus/news/fullstory_53942.
2. Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal: McGill-Queen's University Press,1990).
3. Terry Copp, "Stress Casualties and the Role of the Commander," in Bernd Horn and Stephen J. Harris (eds), *Generalship and the Art of the Admiral* (St. Catharines, ON: Vanwell Publishing, 2001), and Terry Copp, "From Neurasthenia to Post Traumatic Stress Disorder," in Peter Neary and J. L. Granatstein, eds., *The Veterans Charter and Post-World War II Canada* (Montreal: McGill-Queen's University Press,1998).
4. Copp and McAndrew.
5. *British Army Review*, No.3, 1990, p.53.
6. BBC News, 21 April 2000, "MOD Defends Soldier's Treatment."
7. Quoted in Tristan McGeorge et al, "The MOD PSTD Decision: A Psychiatric Perspective," *Operational Health Review,* 122, July/August 2000, p.23.
8. Ibid., pp.24-25.
9. Ibid., p.28.
10. <vac.gc.ca/clients/sub.cfm?source=salute/mar2007/support> (accessed 30 September 2009).
11. Jeanne D. Talbot et al, "Combining CBT and Pharmacotherapy in the Treatment of Anxiety Disorders," *Bulletin Canadian Psychiatric Association*, February 2004. See also, Allison G. Harray, "CBT for PTSD" *Clinical Psychology Review*, 23 (2003), pp.501-522.
12. Travis C. Dancey, "Treatment in the Absence of Pensioning for Psychoneurotic Veterans," *American Journal of Psychiatry*, 1950, pp.101-106.
13. Veterans Affairs Canada, "Post-Traumatic Stress Disorder (PTSD) and War-Related Stress," February 2008. Available on VAC website: <www.vac.gc.ca/pdf/mental-health/ptsd_warstress_e.pdf> (accessed 30 September 2009).

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