

Psychological trauma and the ADF

Rod Milton

ANY MEASURES THE AUSTRALIAN DEFENCE FORCE uses to deal with trauma will be challenged professionally and legally, as traumatologists do not agree on how to prevent or treat emotional disorders arising from distressing experiences. Trauma treatment provides fertile soil for lawyers seeking to induce traumatised (or allegedly traumatised) people to institute legal action. My experience of ADF claimants seeking compensation is that provision of trauma treatment by the ADF increased the size of claims, on the basis that “failed therapy” indicated a more serious condition.

ADF officers tasked with introducing or consolidating trauma management will need considerable courage and resilience to cope with frustration and disappointment. Six hazards are likely to be encountered.

Hazard 1: Vague notions about trauma and treatment

Introducing effective care for psychologically traumatised members of a large organisation poses great challenges. In this “twilight zone”, the ordinary rules of human existence and commonsense can be suspended — lost among such things as glorification of victimhood; counsellors’ tendency to follow fashion; mental health professionals’ propensity to diagnose post-traumatic stress disorder (PTSD) without obtaining objective evidence of the trauma claimed; and a lack of awareness that the validity of the PTSD concept is controversial.¹

The largest and most varied effort at trauma treatment was conducted by the US Veterans Health Administration (VHA) in the 1980s. This study found patients had obtained no benefit at 4 and 12 months after treatment.² This outcome can be understood if one assumes that those treated were not ill (Dr David Bell, forensic psychiatrist, personal communication). Bell suggests that treatment causes these people to spread the harmful idea and accentuate it in those who are

partly affected. Others have also suggested that the VHA does not cure PTSD — it teaches PTSD.³

In another study, from Israel, treated veterans developed more symptoms and disabilities than the controls, although both groups believed the treatment had provided benefit.⁴ If a trauma management program does anything, it should at least not hinder the natural reparative process, as current methods appear to do.

Preconceived notions from psychoanalysis intrude into trauma therapy. For example, it is usual to regard people who recover without help as deceiving themselves (being “in denial”). The trauma industry has little to say about them. Sabine Dardenne was a 12-year-old girl in Belgium when she was abducted and held by a paedophile in a cellar for 90 days. He repeatedly raped and abused her, having already killed four girls he abducted earlier. After release she declined counselling, saying she had to learn to live with the experience herself. Her mother obliged her to see a psychiatrist, but she attended once only and later wrote:

That’s the day I understood that if I wasn’t careful I really would go mad — not with what had happened, but with all the whys and wherefores afterwards.⁵

Hazard 2: Specific problems with the definition of how people react to trauma

The diagnosis of PTSD has been contentious since it was first included in the *Diagnostic and Statistical Manual* in 1980. McNally at Harvard asserts that traumatologists “regard skepticism about the syndromic validity of PTSD as motivated by a malicious agenda to silence the voices of survivors”, but adds that “scholars working outside mainstream traumatology do not consider the diagnosis as exempt from critique”. He concludes, “despite 25 years of research, the PTSD diagnosis remains contentious”.⁶

Hazard 3: Deceit and malingering

Burkett, a US Vietnam veteran, became concerned that some people purporting to be Vietnam veterans and claiming disability pensions might not be.³ He took the trouble (which journalists and psychiatrists did not) to obtain the military records of some people who claimed to be traumatised after service in Vietnam. Many had never been to Vietnam, and some had never been in the armed services. One serviceman had worked in military records and awarded himself an array of decorations for valour in Vietnam; when he was later charged with his wife’s murder, investigations revealed the decorations to be false.³



Group Captain (Retd) Rod Milton is a forensic psychiatrist. He was a Consultant in Psychiatry to the Director-General of Air Force Health Services in the RAAF Specialist Reserve. He was consultant to the Australian government and state police services in counter-terrorism and siege and hostage negotiation. He is a CASA consultant and participated in a working group that formulated current policies for pilots with emotional disorders.

Castlecrag, NSW.

Rod Milton, FRANZCP, FRCPsych, Group Captain RAAF SR (Retd).
Correspondence: Dr Rod Milton, PO Box 4225, Castlecrag, NSW 2068.

Burkett maintained that such massive fraud was possible only because of the readiness of VHA psychiatrists and psychologists to diagnose PTSD without checking the veracity of claimants. He suggested that these professionals were motivated by a need for a continual supply of patients. The VHA budget increased annually by millions of dollars while the number of veterans decreased, but it seemed no action was taken because it would be political suicide to challenge the VHA system.

Hazard 4: The failure of a widely practised treatment

Critical incident stress debriefing (CISD) was invented by a firefighter, Jeffrey Mitchell, who perceived a need among his colleagues to ventilate their feelings after exposure to terrible sights at work. He qualified as a psychologist and introduced discussion sessions among firefighters after distressing events. Over time, these discussions became increasingly formalised and structured. About 1983, I attended a one-day seminar Mitchell ran in Sydney for emergency services. I thought it reasonable for the RAAF to adopt his approach, and attempts were made to implement a CISD plan, but the results were disappointing and the initial enthusiasm declined.

In the general community, CISD was widely implemented. Psychologists set up companies and marketed 24-hour crisis counselling, often employing inexperienced graduates to do the work. The media were much taken with the movement and incorrectly perceived the counsellors who appeared after any disaster as disinterested angels of mercy. A psychologist asked to oversee the management of victims from a Channel ferry disaster told me that many counsellors were as self-motivated as anyone else. Their interest evaporated once media coverage ended, and the victims were left to limited existing psychiatric services.

Despite the immaturity and limited experience of many counsellors, large organisations began to use this service. This may be because judges indicated that employers who did not supply counselling were negligent, and reflected this attitude in their awards.

During medicolegal assessments of employees who had been counselled, I found that most claimed the counselling did not alleviate their distress sufficiently for them to return to work. These claimants invariably complained of relentless incapacitating symptoms. I began to think that claims for emotional injury were greater in counselled people than in those who were not. Others shared these misgivings. Eventually, objective data showed that CISD is actually harmful.⁷

Hazard 5: General criticisms of trauma counselling as useless and intrusive

Wessely, a psychiatrist at King's College, London, was interviewed on ABC Background Briefing on 21 Septem-

ber 2003. He challenged the notion that people exposed to trauma must be psychologically abnormal. He also criticised widespread counselling as being intrusive and unnecessary, saying, "in a general sense now, you cannot get a job or lose a job, you cannot get married or divorced, you can't have or lose children without having counselling." Another participant in the Background Briefing program told of a counsellee becoming upset after CISD because he did not have the symptoms he was supposed to have. He was told that he was "in denial".

Dineen, a US psychologist, has described in detail how illness syndromes are created and published and unhappy people persuaded to undertake lengthy therapy on the basis that it will induce "recovery" (that is, happiness).⁸

An article in *BMJ* in 2002 was critical of trauma counselling, especially when imposed on other cultures.⁹ The devastated Bosnian people were determinedly counselled, but did not receive more necessary forms of help — physical protection, restitution, or justice. They referred to the way they were treated as "bread and counselling".

Hazard 6: Relying on medical authority in a political area

Psychiatrists involved in trauma management sometimes defend their views using statements made by ostensibly independent and unbiased bodies. However, statements by such bodies are not always correct: in 1982, the National Health and Medical Research Council endorsed a paper prepared by a trade union on repetitive strain injury, even though there was no objective basis for the condition. This was followed by one of the worst epidemics of compensation claims in Australia's history.¹⁰ The compensation claims for PTSD now match or exceed that epidemic, on grounds that enjoy medical authority but are not supported by reliable evidence.

Disciplines other than psychiatry appear to be more in touch with the real issues than those whose careers depend on traumatology. Shephard, a military historian, wrote in the introduction to his book on war and psychiatry:

Today, the clinical literature, once so full of hope and optimism, has a chastened and mystified note. Patients, a respected psychiatrist has conceded, are entitled to ask what results 'twenty years of rhetoric about trauma and the treatment of trauma' has actually produced: it is time to put the 'naivete' of the recent past behind us.¹¹

Are there areas of agreement?

Basic needs

People who have had a bad experience are likely to benefit from good physical conditions — food, medical care, accommodation, showers, clean clothing, and being safe. People also seem to be assisted by feeling that others are

genuinely there to help. A matter-of-fact acceptance of distress, basic reassurance, and optimism seem worthwhile.

Fear and how people deal with it

It is normal to feel apprehensive, even overwhelmed, in the face of extreme danger. Soldiers in battle can lose control of bladder or bowels, and that is not a disease. Nor is it abnormal to seek help from people we know when we are terrified or ashamed of being in that state. Indeed, the most immediate and effective help is likely to be from peers, and any formal trauma management program needs to start there. It might be worth training serving members in basic counselling skills; this was used in Vietnam to good effect. Similarly, anything that improves morale and increases the likelihood of people in a unit supporting one another should be implemented.

The most immediate and effective help is likely to be from peers

Medication

Various psychotropic medications have been advanced as likely to help, based on theoretical concepts of the brain and the supposed effect of trauma upon it. However, these theories are increasingly discounted, and recent evidence given in one of the Melbourne–Voyager 1964 collision cases was that it is not now accepted that PTSD can be defined by specific neurobiological responses. The physiological responses once said to give PTSD the status of a “real” disease are absent in two-fifths of those diagnosed with the syndrome.¹²

Given these data, it is unlikely that PTSD is characterised by a specific physiological mechanism and hence unlikely that particular drugs will prevent or cure it, although temporary relief from overwhelming anxiety or agitation through medication is humane and helpful.

There is a problem in rigid adherence to the concept of PTSD as a disease, then seeking to diagnose and treat that concept in real people. The alternative is to try to understand how individuals react uniquely to adverse events. Clinicians sometimes find the diagnosis inadequate to explain the full range of a patient’s symptoms. Thus, they add multiple “comorbidities”. This diagnostic system is so verbally cumbersome as to be an insult to the English language and an impediment to clear thought, especially for anyone trying to help distressed patients.

Interactive therapy

Some patients seem to benefit by going over the distressing event in depth, especially if the event evokes pre-existing conflicts, although such therapy should probably be limited in aims and duration. Therapy often continues interminably, especially when financed by third parties, but I doubt that encouraging prolonged ventilation of emotion helps traumatised people.

One interactive treatment currently said to show promise is cognitive behaviour therapy. However, despite the initial promise of cognitive behaviour therapy, it would seem unwise to implement it as a general approach until it has been thoroughly tested. One study showed that people receiving cognitive therapy did as badly as those treated by imaginal exposure.¹³

Israeli work on trauma has suggested that people who have the ability to disregard (in Freudian terms, repress) bad experiences do better than those without this capacity.¹⁴ That is, the stiff-upper-lip types have the edge on those who let it all out.

Conclusion

Military administrators introducing measures to deal with trauma in service personnel should be wary of accepting the recommendations of experts on reputation alone. The extensive literature on trauma compiled over nearly a quarter of a century contains no agreed-on method of preventing the emotional effects of trauma or of effectively treating those who suffer them.

Competing interests

None identified.

References

1. Shorter E. A history of psychiatry. New York: John Wiley & Sons, 1997.
2. Johnson DR. Introduction: inside the specialized inpatient PTSD units of the Department of Veterans Affairs. *J Traumatic Stress* 1997; 10: 357-370.
3. Burkett BG, Whitley G. Stolen valor: how the Vietnam generation was robbed of its heroes and its history. Dallas, Tex: Verity Press, 1998.
4. Van der Kolk BA, McFarlane AC, van der Hart O. A general approach to treatment of posttraumatic stress disorder. In Van der Kolk BA, McFarlane AC, Weisarth L, editors. Traumatic stress: the effects of overwhelming experience on mind, body and society. New York: Guilford Press, 1996; 417-440.
5. Dardenne S, Cuny M-T. I choose to live. Sydney: Penguin, 2005.
6. McNally R. Conceptual problems with the *DSM IV* criteria for post-traumatic stress disorder. In: Rosen G, editor. Post-traumatic stress disorder issues and controversies. London: John Wiley & Sons Ltd, 2004.
7. Psychological debriefing for preventing post traumatic stress disorder (PTSD) [Cochrane review]. The Cochrane Library, Issue 4, 2001. Oxford: Oxford Update Software.
8. Dineen T. Manufacturing victims: what the psychology industry is doing to people. Montreal: Robert Davies Multimedia Publishing, 1996.
9. Summerfield D. Effects of war: moral knowledge, revenge, reconciliation, and medicalised concepts of “recovery”. *BMJ* 2002; 325: 1105-1107.
10. Lucire Y. Constructing RSI: belief and desire. Sydney: UNSW Press, 2003.
11. Shephard B. A war of nerves: soldiers and psychiatrists, 1914–1994. London: Jonathan Cape, 2000.
12. Orr SP, McNally RJ, Rosen GM, Shalev AY. Psychophysiological reactivity: implications for conceptualising PTSD. In: Rosen GM, editor. Posttraumatic stress disorder. Issues and controversies. Chichester: John Wiley & Sons, 2004.
13. Tarrrier N, Sommerfield C, Pilgrim H, Humphreys L. Cognitive therapy or imaginal exposure in the treatment of post-traumatic stress disorder. *Br J Psychiatry* 1999; 175: 571–575.
14. Slater L. Repress yourself. *New York Times* 2003; 25 Feb: 48.

(Received 11 May 2005, accepted 20 Jun 2005)

□