ECRONICON OPEN ACCESS

EC PSYCHOLOGY AND PSYCHIATRY
Short Communication

From World War I to the Attack in Nassiriya. What we knew and what we learned about Post-Traumatic Stress Disorder

Sara Palermo*

Department of Psychology, University of Turin, Italy

***Corresponding Author**: Sara Palermo, Department of Psychology, University of Turin, Turin, Italy.

Received: November 15, 2019; **Published:** December 04, 2019

Brief history of the difficulty in recognizing the "illness of war"

The First World War was a tragic natural experiment: during the conflict modern psychiatry acquired for the first time the idea that the stress of war could get soldiers to go mad. Psychiatrists started talking about "trench fever" to try to explain the anomalies associated with combat stress. The English called it "shellshock": the soldiers hit by the mysterious syndrome had a variety of symptoms: palpitations, tremors, paralysis or tremors all over the body, nightmares, insomnia; sometimes they stopped talking. Some seemed to lose their mind forever, others recovered after a period of rest. A new treatment (forward psychiatry) was proposed, but it did not offer the solution to the management of psychiatric casualties, On the centenary of the outbreak of the First World War, the Lancet magazine dedicated an article to reconstruct the story of shellshock: Battle for the mind: World War 1 and the birth of military psychiatry by Edgar Jones and Simon Wessely (2014). The article takes into consideration above all the case of the case of Great Britain, but it was not only English soldiers who suffered from a form of neurasthenia or "exhaustion of unknown origin". The strange syndrome that knocked out the military was widespread on all fronts. The Italians called it "wind of the howitzers". Various causes were hypothesized. The first idea was that it was an organic disorder, caused by physical damage to the brain consequent to exposure to explosions. It was thought that the blast of the explosion, even without killing, could still damage the brain. However, it soon became clear that this was not the case. The doctors began to wonder about other possibilities, the psychological ones first of all. The idea prevailed that in the soldiers in which the disturbance occurred there was a fundamental vulnerability, which the harshness of the war and the conditions at the front caused to explode. However, the experts were soon forced to admit that the war apparently caused people who had not registered any particular predisposition or hereditary defect to fall ill or go crazy. The war itself seemed to be a cause of disease. Hospitals were established near the front to accommodate not only not only those who reported physical injuries but also those who showed signs of mental distress (40.000 in Italy, according to estimates), who were sometimes treated and sent back to the front, sometimes they were interned in a mental hospital, if the symptoms seemed too strange or serious to be managed in field hospitals. The main concern was that the madness of the soldiers thinned the ranks of the combatants too much. Among psychiatrists, the idea prevailed that in many cases it was a simulation, and a sort of obsession was born to try to unmask those who pretended to be symptoms.

In the Second World War, the term "Traumatic War Neurosis" was adopted. During the Vietnam War the definition went from "Strong Stress Reaction" to "Adaptive Disorders of Adult Life". After that war, the years of the great peace marches in which thousands of veterans participated in increasing numbers arrived. Many soldiers had returned home to the threshold of madness, several had really gone mad; this epidemic was categorized as a mental illness, becoming the "Vietnam syndrome" in common language.

The recognition of the "Post-Traumatic Stress Disorder" (PTSD) occurred only in 1980, following the study of war veterans. PTSD was coined to define the set of symptoms that affect soldiers and people who have experienced dramatic events or natural disasters that have put their lives at risk. More recently, "Post-Deployment Syndrome" has been proposed to incorporate all the signs and symptoms experienced because of the injury, deprivation, trauma, and stress of combat.

While European statistics in 2011 attested the average of PTSD among the contingents was 4 - 5%, it reached 20 - 30% in the United States and 3% in Great Britain, but with controversial data from criminal records: about 10% of prisoners in British prisons came from the armed forces, imprisoned mainly for domestic violence related to alcohol and drug abuse. At that time, Italian statistics reported only two or three diagnoses a year, considering approximately 150,000 soldiers employed abroad between Lebanon, Iraq and Afghanistan. Official statistics show that the phenomenon is practically non-existent in Italy. Like other diseases, Italy should expect a similar incidence to other countries, suggesting that the phenomenon has not been detected. The reasons for this underestimation could be manifold. It is in the interest of the Institutions not to admit that the activities that Italian soldiers carry out abroad are "also" of a military nature; it is in the soldiers' interest to hide the malaise so as not to be forced to leave the armed forces; it is in the interest of military hierarchies to minimize the phenomenon to avoid alarmism. Nevertheless, some testimonies issued by veterans of the massacre of the Italian compound in Nassiriya in 2003 seem to suggest a different reality. In March 2003, the Iraqi Freedom (OIF) operation began. On 1 May 2003 the war is officially over, although the coalition the have never had full control of the territory, suffering severe losses due to recurrent attacks. Italy participates through the peacekeeping operation "Ancient Babylon" which began on 15 July 2003. On November 12, 2003, a first serious attack in Nassiriya took place. At 10:40 am local time, a tanker truck full of explosives burst in front of the entrance of the Multinational Specialized Unit base, subsequently causing the explosion of the base ammunition depot. The attack caused 28 deaths, 19 Italians and 9 Iraqis.

PF attacked his 14-year-old son since he believed he was under attack. It was in his mind. PF reported: «I only remember that my son gave me a pat on the shoulder. "Hi Dad!" He said. I do not remember anything else. Only the neighbors tried to get it out of my hands». From that day, when he feels a bit "strange" he recommends to his wife and children: "Lock me up from the outside and if you feel you beat do not worry, it is I who slams my head into the wall".

PS became irritable about everything and lost sleep: "We walked around the base, where we saw dogs or flies, we knew there were remains of our companions, we gathered them with our bare hands and threw everything in rubbish bags. Those images became the "film" that my mind projected to me, often during an operational intervention. A siren, smoke. I live the intervention on one side, the succession of the events of September 12, 2003 overlapped on the other. Anything could be a piece of a dead colleague of mine".

From Iraq to Afghanistan, international military missions in recent years have seen the incidence of PTSD increase. Once again, the experience of combat and the tragedy of war leave deep signs in soldiers. There is not only the fighting front. Post-traumatic stress disorder can occur in case of fighting and gunfire, for accidents during training. Other times it is linked to the participation of military personnel in certain events, such as natural disasters or a humanitarian emergency. In the decade 2003 - 2013 there would have been 241 suicides among the members of the Italian Armed Forces. Numbers to think about.

Post-traumatic stress in the military

Post-traumatic stress disorder symptoms may start within one month of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships. PTSD symptoms are generally grouped into four types: intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions. Symptoms can vary over time or vary from person to person.

Among the military personnel, there are a number of factors that worsen the symptoms and are associated with the specificity of the training and operational theaters in which soldiers are employed:

- Military training, aimed at maintaining a state of hypervigilance and which makes soldiers dangerous for themselves and others in the event of a badly managed violent attitude;
- Longitudinal chain of command and impossibility to discuss the authority of superiors;

- Peculiarities of returning home and reintegration. Feelings of abandonment, uselessness and loss can arise. Many soldiers feel they are no longer part of their lives. They may come to feel guilty for surviving the war and their companions;
- Residual stress that carries over from a combat deployment, memories of conflict and operational theater.

It is important to focus on Post-Deployment Syndrome (or PTSD) as a combat injury that can get worse because of combat stress reactions and that it can involve the onset of chronic neuropsychiatric, neuropsychological and socio-functional sequelae. Friendship, family and social support is not only a preventive factor both before and after exposure to the event but turns out to be a favorable prognostic factor in the long run. Another very important tool is psychoeducation, with which to prevent symptoms. Preventive psychotherapy is a very positive tool to prepare soldiers for the emotions they can experience when they are on duty and during the reintegration phase.

Clinical intervention is particularly complex. It is more effective if it begins immediately after the traumatic event. This helps reduce the discomfort and complications that may arise. A technique widely used is the debriefing, useful for the integration and awareness of traumatic events experienced by the group.

Over the years, many long-term intervention strategies have been attempted that have shown good results. One of the most accredited strategies is the Eye Movement Desensitization and Reprocessing (EMDR), a treatment technique that facilitates the processing of trauma by patients, exploiting bilateral stimulation. Mindfulness too, and especially the Mindfulness-Based Stress Reduction (MBSR) program has proven effectiveness in reducing post-traumatic symptoms. Cognitive Behavioral Psychotherapy focused on trauma and Narrative Exposure Therapy are particularly used and effective. In particular, the latter is based on the narration of traumatic events to reduce the symptoms related to the trauma and to favor a coherent reconstruction of one's own history, useful for recovering one's identity and personal dignity. Indeed, the war trauma splits up memories or their precise location over time, generating inevitable confusion in the person, doubts about the veracity of the events and about the responsibilities of the same. These factors can maintain and worsen psychological distress. The priority element is to adapt the therapy to the specific case of each individual soldier. The therapy can be applied individually or with group sessions; the latter are very effective when the groups are particularly homogeneous.

A wide range of innovative therapeutic approaches have been proposed over time to complement and supplement cognitive-behavioral treatment protocols - and, ultimately, to help clinicians transcend the limits of those protocols. Veterans suffering from mTBI/concussion and PTSD who do not benefit from traditional cognitive-behavioral therapy can now count on more creative approaches: expressive-experiential or art approaches; mind-body approaches; animal-assisted and outdoor approaches; technological and web-based approaches; return to work approaches; spirituality approaches. New approaches to psychotherapy for PTSD without re-experiencing trauma memories have also been developed.

In addition, among the emerging approaches for the treatment of PTSD are Sensomotor Therapy and Sensitive Yoga Trauma.

Despite the progress made, Greater sensitivity to the psychological well-being of soldiers, future research and dissemination efforts are needed.

Volume 9 Issue 1 January 2020