AMERICAN EX-PRISONER OF WAR, INC.
NATIONAL MEDICAL RESEARCH COMMITTEE

STRESSES OF INCARCERATION
AFTER-EFFECTS OF EXTREME STRESS
PSYCHOLOGICAL
NEUROLOGICAL
RESIDUAL NERVOUS CONDITIONS

Packet 2

Updated January 1991

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"WE EXIST TO AID THE MAN WHO CANNOT HELP HIMSELF"

CENTER GREEN INSERT ANY OF THE ANXIETY STATES

As you know the "FORMER PRISONER OF WAR BENEFITS ACT OF 1981" (Pulic Law 97-37) was signed by the President, effective October 1, 1981. I will do my best to explain two of the provisions in the new law which applies to veterans who were POWS for not less than 30 days.

The DISEASE OF PSYCHOSIS OR ANY OF THE ANXIETY STATES, which become manifest to a degree of 10% or more after active military, naval or air service shall be considered to have been incurred in or aggravated by such service, notwithstanding that there is no record of such disease during the period of service.

Let me explain PSYCHOSIS and ANY OF THE ANXIETY STATES are PRESUMTIVE DISORDERS for service connection, but IT REMAINS FOR YOU, THE EX POW, TO HAVE THE SYMPTOMS AND BE SO DIAGNOSED by a physician. IT IS NOT AN AUTOMATIC COMPENSATION.

Defination of PSYCHOSIS by Alvin C. Poweleit, M.D.: PSYCHOSIS, is a general term for any major mental disorder of organic and/or emotional origin characterized by DERANGEMENT OF THE PERSONALITY AND LOSS OF CONTACT WITH REALITY, OFTEN WITH DELUSIONS, HALLUCINATIONS, OR ILLUSIONS.

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Following are some definations for the Green Insert:

AGORAPHOBIA - Morbid dread of open spaces

AUTONOMIC - Spontaneous, self controlling [nervous system - A part of the nervous system which is concerned with control of involuntary bodily functions. It controls function of glands, smooth muscle tissue and the heart.]

CONCOMITANT - Accessory; taking place at the same time

DYSPNEA - Air hunger, resulting in labored or difficult breathing, sometimes accompanied by pain. Is normal when due to vigorous work or atheltic activity.

DYSPORIA - State of restlessness; disquiet, malaise

IDEATIONAL - Relating to the process of thinking; formation of ideas. It is slow in DEMENTIAS [irrecoverable deteriorative mental state, the common end result of many entities], depressions, and other organic brain diseases, and in narcotic intoxications, but quickened in early stage of intoxications. It is unduly active in manic-depressive insanity.

[ENTITY - ENTITIES - A thing existing independently, containing in itself all the conditions necessary to individuality.]

LABILITY - State of being unstable or changeable

RUMINATION - 1. REGURGIATION, exp. with rechewing of previously swallowed food.

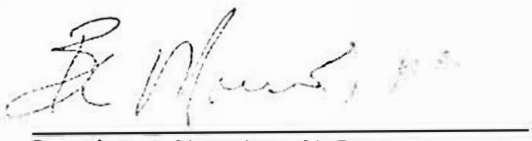
2. IN PSYCHIATRY, Obsessional preoccupation of mind by a single idea or a set of thoughts, and inability to dismiss or dislodge them.

STRESSES OF INCARCERATION
PSYCHOLOGICAL - NEUROLOGICAL

FOREWORD

Of all the organ systems in the body, the Central Nervous System, with all its peripheral extensions, is far and away the most complicated. Probably because of its intricacies, it is also the most susceptible to abuse and privation. Because of its inability to reproduce cells to replace dead or damaged elements, an insult that results in damage is present from that moment onward, perhaps compensated by other means, but never repaired. As time progresses and the compensatory mechanisms wane, the damage suffered long before begins to surface and can even give the impression that it is a "new disease", rather than an old one no longer camouflaged. This is the most common pitfall into which physicians fall when dealing with the Ex-POW, or for that matter anyone who suffered severe deprivation in younger years; yet is being evaluated in middle age.

The Central Nervous System does much more than simply make our legs move and skin sensitive. The temporal lobes of the brain are where a man "lives". It is the seat of our emotions, the home of hope and fears and anger. It need not suffer physical damage to be impaired. Stimuli it receives from the eyes and ears (as well as from itself in the form of thoughts) can cause severe damage, though its physical form remains intact. If the trauma is severe enough for a short period of time, almost irreparable damage can occur. If a remedy is ten to thirty years too late, this problem has had time to crystallize and proves very difficult to eradicate. However, supportive means can make it much more comfortable to bear. I hope this booklet will allow the supportive care to be more accessible and give some hope to many who have lost it.



Brock A. Morris, M.D.

CONTENTS

"PRISONERS OF WAR ARE SOLDIERS, SAILORS, AIRMEN, MARINES OR CIVILIANS. THEY ARE NOT WAR CRIMINALS; THEY ARE VETERANS OF THE MILITARY SERVICES OR CIVILIAN AGENCIES. AS MEN OF HONOR THEY REPRESENT AN UNFORTUNATE GROUP, VICTIMS OF ENEMY CAPTURE, TAKEN WHILE FIGHTING FOR THEIR COUNTRY. IT MUST NEVER BE THAT THEY ARE STRIPPED OF THEIR SELF RESPECT, THEIR DIGNITY OR THEIR INHERENT RIGHTS AS HUMAN BEINGS OR AS VETERANS OF THEIR COUNTRY'S COMBAT FORCES. IT IS IMPOSSIBLE TO RELIEVE THEIR HARDSHIP AND SUFFERING, THEIR LONELINESS, THEIR PHYSICAL AND MENTAL ILLNESSES AND DISORDERS, OR TO EVEN REASSURE THEM WITH RESPECT TO THEIR FAMILY AND LOVED ONES. THEY HAVE NOT BEEN FORGOTTEN - THEY MUST NEVER BE FORGOTTEN."

RAYMOND W. MURRAY, M.D. MEDICAL CONSULTANT, V.F.W.

INTRODUCTION

Never before in this country's history has such a large group been exposed to starvation, torture (both physical and psychological); inhumane treatment as have the 130,000 plus Americans who have been held prisoners by the Japanese, Germans, North Koreans, North Vietnamese, Viet Cong and other Axis powers.

Dr. Albert Haas, New York University, believes that many symptoms found in former camp prisoners today are either mis-interpreted or overlooked in diagnosis. He urges physicians in private practice to acquire more information about the late sequelae of starvation and stress, so that they will be better able to recognize and manage these conditions.

In this packet, requested by the Ex-Prisoners of War, we have attempted to give a general survey on studies that have been published on the after-effects of extreme stress.

You may feel that certain studies have been incompletely treated in this packets. If so, note the listed title and references which give a more detailed account, and refer to your local library. A Packet such as this can only hi-lite.

The present knowledge in the area of after-effects of imprisonment is limited and more research is needed. The results of further research would help all Ex-Prisoners of War and all people who suffer throughout the world from starvation and the stresses of imprisonment now and yet to come. There may be preventative measures taken for the future misfortunates, so they never experience our problems in the years to come.

This packet is for the benefit of all Ex-Prisoners of War as well as their spouses and children so that they may better understand their health problems. Also for anyone who in one way or another becomes engaged in supporting the cause of the Ex-Prisoner of War.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR HEALTH, PLEASE CONSULT YOUR PERSONAL PHYSICIAN OR THE VETERANS ADMINISTRATION PHYSICIAN----THEY WILL HELP YOU.

GENERAL ADAPTATION SYNDROME

BY

Perry M. Nealis
University of Wisconsin
EX-POW BULLETIN, March, 1975
Pages 21-22

Whenever there is a discussion on stress we must take into consideration Hans Selye (1969) General Adaptation Syndrome, Or G.A.S. Concept.

"The G.A.S. model describes the three stages which characterize in organism's response to stress: ALARM, RESISTANCE, and EXHAUSTION. Selyes' contributions in this area consist of the successful identification of certain physiological processes which accompany stress reactions, and their subsequent effects on the organism. Although many psychologists, physicians and physiologiests may not subscribe to Selyes; theory that all diseases stem from stress, the G.A.S. concept has been confirmed in several studies involving both human and animal reactions to stress.

The changes are characteristic of the response of the autonomic nervous system to stress induced by physical agents (noise or painful stimuli such as, electric shock). These effects can also be produced by fear-evoking situations, prolonged sleep deprivation, and a host of other less tangible stressors. In general, these initial reactions to stressful condition typify the ALARM stage of the G.A.S..

The RESISTANCE stage is characterized by physiological processes returning to normal activity levels. So that in this stage ones heart rate may return to normal even though the individual is still being stressed. Additionally, an individual's behavior may be quite "normal" under such conditions. The individual may perform as though no stressor is present.

However, the EXHAUSTION stage usually follows the body's attempt to adapt to adverse conditions. Consequently, under prolonged stress the body may simply fail to function properly.

Seyle maintains that chronic illness may result when an individual reaches the EXHAUSTION stage and can no longer cope with continued stress. A person in this condition may not necessarily act exhausted. The exhaustion, here, refers to the inability of certain physiological mechanisms to respond appropriately to additional stress.

How does all of this relate to the ex-POW's situation. The answer is neither a simple nor a straight-forward one. But, the findings cited here suggest that humans subjected to severe, prolonged stress may be susceptible to certain illnesses or disturbances because such stress renders them incapable of adapting to the stress of day-to-day existence.

It goes without saying that active combat and incarceration in POW prisons are extremely stressful experiences. In fact, the POW's experiences are so unique that it is difficult to imagine human conditions which might be considered more stressful. Therefore, it is reasonable to evaluate the ex-POW's situation in terms of the G.A.S. concept.

"...TENSION - IRRITABILITY - INSOMNIA..."

Although a comprehensive study of ex-POW's medical problems has not been conducted, a related study of combat veterans suggests the G.A.S. concept may be relevant to our understanding of the overall scope of illnesses suffered by ex-POW's. (Archibald, Long, Miller and Tuddenham, 1962). The typical combat veteran reports (to varying degrees) such diverse symptoms as tension, irritability, headaches, insomnia and nightmares. Their inability to cope is apparent even in mild stress situations. Of particular interest is the fact that combat veterans show a low tolerance for noise, even avoiding environments that are considered relatively "quiet" by non-combat veterans and civilians. Even psychiatrically well combat veterans show marked physiological and behavioral responses to sudden noises. Additionally, many of these symptoms appear to reflect to G.A.S. symptoms.

We know that stress can be produced by psychological as well as by physical agents. Little is known about the long-term effects of psychological stress which arises from experiences with severely stressful events. How does stress produced by frightful memories of past atrocities affect individuals who have lived those memories? Even though one may survive extremely stressful experiences and appear to have retained the ability to cope with additional stress, this ability may be weakened by the stress-inducing memories of those past experiences. The stress of any past event may continue for as long as one remembers that event.

Who can then venture to say that drastic consequences may result from continued stress of this magnitude? The G.A.S. theory predicts that these individuals could eventually become physiologically and behaviorally "helpless" in the face of stress which continues to emerge from memories.

Answers must be made available to those who know too well the hardship of life under continuous stress. Perhaps learning to forget can be accomplished by new therapeutic techniques. Whatever, the answer, there are undoubtedly numerous individuals who would benefit from such research, especially those whose wartime experiences are still alive and posing threats to their health.

REFERENCES:

Archibald, H.C.; Long, D.M.; and Tuddenham, R.D.

GROSS STRESS REACTION IN COMBAT, a 15-year follow-up.

American Journal of Psychiatry, 1962, Vol. 119, pages 317 - 323

Psychology Today, "IT'S A G.A.S." by Selye, H., 1969, Vol. 3 (4), Pages 25 - 27

"NEUROPSYCHIATRIC EXAMINATION OF MILITARY PERSONNEL RECOVERED FROM JAPANESE PRISON CAMPS"
Lt. Col. Norman Q. Brill
Medical Corps
Army of the United States
Vol. V, No. 4, April 1946---4677 Men Examined

"Following release from prison camp some developed increasing anxiety, feelings of inadequacy, and one man became psychotic. The development of the anxiety is interesting. The longer they were out of prison, it seems, the greater the anxiety became. These dynamic factors were not uncovered. Some admitted having some apprehension about the future. They felt that they had lost ground and had to do much to catch up.

Overt anxiety was by far the most common single symptom presented. There were a few instances in which men had crying spells when they were off by themselves. They tried to conceal these emotional outbursts and would acknowledge them only after repeated questioning.

As expected, because of the severe dietary restrictions, polyneuritis (polyneuropathy due to Vitamin B deficiency) was the most common disorder. Some evidence of peripheral nerve involvement was found in 13.1 percent of the entire group; however, most of these did not show severe impairment. Superficial sensory loss, frequently patchy and generally in the lower extremities, was the most common manifestation (10.3 percent).

Comment: Did this group of survivors have any basic quality or qualities which enabled them to survive? They have all experienced a shattering emotional period. During confinement they were starved, frequently beaten, and subjected at all times to the fear of death. They received little news of the outside world. Many had no word of their families during the entire period of imprisonment. Weight losses of 65 to 100 pounds were common. Disease was present at all times; pneumonia, dysentary, malnutrition, and vitamin deficiencies exacted heavy tolls."

REPATRIATED PRISONERS
Brigadier General Hugh J. Morgan, U.S.A.

It is difficult to define, but the men who did not give up were characterized by some of the following qualifications:

1. They had a never-failing hope of rescue.
2. They were possessed of a high morale and courage.
3. They were individuals who adjusted rather easily to difficult situations.
4. They were nonaggressive or at least were able to control a tendency to pugnaciousness which, if allowed to evidence itself, frequently resulted in summary death.
5. They were willing to eat anything, however disagreeable, if it might contain nutritional value.
6. They were willing to secure food by any and all means. The stealing of food from the Japs became a highly specialized technique. In one camp at the time of release, the prisoners had more than 2,000 pounds of beans hidden away in diverse places.

"ADDITIONAL HI-LITES

Doctor Charles T. Brown
Prisoner of War, Japan

Whenever a group of ex-prisoners of war get together and discuss POW's and their medical problems, we repeatedly hear the name of "Charlie Brown".

Dr. Charles T. Brown retired from the regular Army as a Colonel and sometime later retired from private practice. He is a Diplomat of the American Board of Psychiatry and Neurology.

Having been a prisoner of the Japanese for 44 months he suffered all of the Hell of Imprisonment as well as the after-effects right along with the rest of us.

Over the past 30 years he has helped thousands of ex-prisoners of war with their health problems and claims with the Veterans Administration.

Many Medical Articles about POW's have been written by Dr. Brown and published in Medical Journals.

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In late 1947, while on duty in the Surgeon General's Office in Washington, D.C. there was considerable concern over the "health of former prisoners of the Japanese". This was called "Project J" by the War Department, as I recall. As a result of the concern felt by the War Department there was a brochure printed by the Government Printing Office containing certain findings of various investigative committees. I testified before one such Senatorial Committee headed by the late Senator Dennis Chavez of New Mexico. The concensus of the testimony given by some 15 physicians, both ex-POW's and some not ex POW's, was that IT WOULD BE IMPOSSIBLE for a human being to sustain life on the food given to the Japanese Prisoners of War.

The late Senator Chavez said to me: "Well, I am indeed surprised that ANY OF YOU returned from the Japanese Prison Camps!"

I did not tell Senator Chavez that he was talking to a dead man and did not know it!

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STRESSES OF INCARCERATION
AFTER-EFFECTS OF EXTREME STRESS
Dr. leslie Caplan
Prisoner of War, Germany

Living in the most opulant society the world has ever known, it is not easy for us to put ourselves in the place of, and think like, a prisoner of war.

One physician who did try to understand the prisoners of war was the late Dr. Leslie Caplan, himself a prisoner of Nazi Germans in World War II and whose subsequent career was permanently colored by this experience. It is not unlikely that his decision to enter psychiatry was influenced by his tortured life at the hands of the Germans. He developed the thesis that all veterans who have been prisoners of war should receive service-connected disability.

In September, 1969, a symposium was held at the Minneapolis Veterans Administration Hopital to honor Dr. Caplan. One of the papers presented at this symposium is published in this issue.

Leslie Caplan was a flight surgeon on a mission out of Italy flying over Vienna in a B-24 in October 1944 when his plane was hit. The crew bailed out over Yugoslavia where he was taken prisoner. He was sent to Pomerania where, in February 1945, his entire camp of 2,600 men were marched out on a journey covering 600 miles in 86 days. Freezing, living in filth, disease and on a starvation diet, it was a nightmarish experience ending only in liberation by the allied armies on May 2,1945.

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"THE JAPANESE POW SYNDROME"

Quoting from "THE SHORT FUSE" by Major Charles T. Brown, MC (Colonel, Retired, M.C.) Printed in: DISEASE OF THE NERVOUS SYSTEM; Vol.X; No. 11, November, 1949.

"One of the gaunt and emaciated skeletons who passed thru the gates of Old Bilibid, (Manila, P.I., February 1945) was heard laughingly to remark, that although free, it was his belief that the Japanese had placed an invisible hand grenade about his neck .....set with a very short fuse.

Following, homecoming, and when the shouting had subsided, there became manifest a malady so characteristic and so frequently encountered among ex-prisoners, that it has been a psychiatric entity. This psychiatric disorder, for lack of a better descriptive term, has been called the JAPANESE POW SYNDROME. It has been essentially an anxiety reaction of a most severe and chronic nature. So protean are its manifestations, the disease with its usual psychosomatic coloring, might also be termed the "anxiety rainbow", inasmuch as those so afflicted, manifest the entire spectrum of the anxiety state. The affliction was born out of the agaony of BATAAN and the despair that was CORREGIDOR, to be nutured by three and a half long years in the fertile soil of danger, misery and starvation. Simmering in a vertiable witch's cauldron... the affliction did not reach its full maturity until transplanted to the shores of the United States.

Anxiety, like the pangs of hunger, was a part of the daily existence of the POW. He (also) had to reckon with the ravages of nutritional disorders, dysentery, malaria and other tropical diseases incident to his imprisonment. The residual of these difficulties was the equipment he brought home with him.

The typical case of POW SYNDROME encountered is that of the well integrated pre-was personality who has been rendered more or less non-effective due to his experiences as a Japanese Prisoner. It may be postulated that men who were well integrated prior to the War have, as a rule, made the best adjustment. However, hundreds of this class of individuals have suffered from the malady under discussion. The clinical picture is indeed puzzling to the average physician, due to the fact there may be no

objective findings of organic disease. It must be considered that there remains the possibility of obscure pathology. Their complaints are usually all out of proportion to the findings and in some cases one can only marvel at the paucity of pathology, considering the experiences which they have survived. Let us not be misled; many prisoners have returned from the Japanese wearing the mask of good health."

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"A PRISONER OF WAR SYNDROME"
"APATHY AS A REACTION OF SEVERE STRESS"

Harvey D. Strassman,M.D.; Los Angeles,CA., Margaret B. Thaler, Ph.D., and Capt. Edgar H. Schein, M.S.C., Washington,D.C. AMERICAN JOURNAL PSYCHIATRY 112: 998, 1955

Summary and Conclusions

"We have pointed out that one defensive adjustment of POW's to stress is withdrawal. If the stresses are not too severe the person will withdraw physically, if possible, or in any case will refuse to allow himself to become involved with the environment to as great an extent as possible. Certain kinds of overt behavior will be inhibited and most emotional responses will be suppressed. If the environment is severly stressful and physically depriving as well, the individual may regress into a more complete withdrawal and adopt a maladaptive state of dependency in which he ceases to take care of himself even to the point of death. We have labelled this type of defense "apathy" and distinguish it from states like catatonic stupor, or depression. "Apathy" appears not being a single absolute reaction, but a syndrome which can vary markedly in degree. One major symptom in the syndrome is reduced or modulated affect, but only in extreme cases can one speak of true apathy or affectlessness. Other symptoms are listlessness, uncommunicativeness, lack of spontaneity, indifference, slowed reactions, lack of enthusiasm, and lack of initiative. It is important to note that underlying the overt lack of emotional spontaneity may lie great quantities of pent-up feelings, and that these will continue to be a problem to the individual when he is no longer in the environment that produced the "Apathy Syndrome".

The "APATHY SYNDROME" serves to maintain personality integration in the face of severe reality and psychological stresses.

"LATER EFFECTS OF IMPRISONMENT AND DEPORTATION"

International Conference organized by the World Veterans Federation, The Hague, November 20 - 25, 1961

"The later asthenia of deportees were stressed. The clinical description of this ailment is confirmed by the body of reports and statements which were submitted. The most recent research reveals, on the basis of clinical and supplementary neurological investigations of a group of 100 ex-concentration camp prisoners, that 96 of them had symptoms and signs of organic lesions of the central nervous system and about 2/3 of the group examined showed signs of lesions of the peripheral nervous system as well, resulting from the stress to which they were subjected in the camps. This meningo-ence-phalopathy is of a degenerative character and has a gradually progressive tendency."

"LIBERATION AND THE FOLLOWING YEAR"

Charles Richet, "Academie de Medene", Paris, France.

Myocarditis, tuberculosis, and denutrition, when these were untreatable disorders or lesions, continued to destroy.

From 1947 to 1955--THE STAGE OF EARLY AFTER-EFFECTS.

All the organs affected: myocarditis, stomach ulcers, psychic disturbances, rheumatism, tuberculosis, the latter, it is true, being already less frequent. In this period, morbidity and mortality were higher than among our contemporaries.

TODAY, we are living in THE PERIOD OF DELAYED AFTER-EFFECTS.

The present Conference exponds the teaching of the Oslo meeting which demonstrated that all systems, all organs affected in the past were still affected sixteen years later.

Before going into details, let us mention the three main factors which have turned the deportee into a constantly ailing person.

1. Job fatigue does not appear at the beginning of old age. but in adults who are still young.
2. Old age is premature
3. Early death occurs.

The cardiovascular and nervous systems, although not the only ones to be impaired, are more often those to be affected and this always leads to serious developments.

I do not wish to anticipate the reports which will be submitted to you, but I trust I may be permitted to mention the most important points.

The nervous system is disturbed in the case of more than half of our comrades. The commonest sign, so common that we now regard it as normal, is fatigue. This appears after any slightly long walk, as a result of going out in the evening, getting up too early, or any overwork. Hypersomnia is invariable; lengthy daytime rests are essential.

The Norwegian and French experts at Oslo emphasized psychic disturbances. They are studying them again today and the opinion of these psychiatrists: OSVIK, ROGAN, EITINGER, STROM, GRONVIK, LONNUM, TARGOWLA, RAVEAU, is one of the greatest value. Psychic and characterial functions often cease to be normal. Cardiovascular disorders are very frequent. Our friend Invona shows the development of myocarditis cases since 1944 which continue to advance. They lead to those delayed deaths due to a heart disease which Mans and I emphasized, death through sclerosis of the myocardium, of the coronaries, of the aorta or by senile myocarditis.

FOLLOWING ARE THE CONCLUSIONS AND FINAL RECOMMENDATIONS OF 48 DELEGATES, WHO ARE EXPERTS ON THE LATER EFFECTS OF IMPRISONMENT AND DEPORTATION.

In conclusion, the conference was of the opinion that there exist ailments and disabilities which appear long afterwards among persons who were interned or imprisoned in concentration camps.

These effects can become manifest at any time after liberation, and no time limit can be set for their appearance.

Similar effects can be observed among persons who have lived under dangerous and stress conditions as a result of their fight against nazism.

These effects can also be found among former prisoners of war who lived under exceptional conditions of stress.

The conference was of the opinion, on the basis of the above medical conclusions, that it is necessary:

1. To eliminate, for the persons concerned, all legal time limits for submitting applications in connection with disability
2. To have them benefit from the presumption of origin and aggravation, without time limit, which excludes any provision tending to reduce the disability rate on the grounds of the applicants age or because of the time when application for pension was made.

The conference recommends, in general, the adoption in the various countries of a system of reparations based on the principles set down above.

Without prejudice to more favorable or similar legal provisions, the conference recommends in particular the following measures:

1. Granting to deportees who were subjected to the concentration

camp system, an outright disability percentage intended to compensate for special physical and psychic diminution suffered by the persons concerned as a result of the exceptionally severe conditions of their internment, this percentage to be granted in all cases and possible to be added, arithmetically, to the disability rate already recognized for specific ailments.

2. Creation of commissions established solely in connections with the medical examination of former deportees.
3. Possibility of applying for early retirement and payment of the entire salary and for all other possible advantages, which would be guaranteed until the legal pension age.
4. Completely free medical care, both preventative and curative.

The conference requests the World Veterans Federation to call upon all governments and upon the medical profession to promote specialization in post-concentration camp pathology.It urges that the conclusions of the studies that have already been pursued in this field and that new medical knowledge resulting there from be widely publicized.

"PATHOLOGY OF THE CAPTIVITY OF THE PRISONERS OF WAR"
Tome II, Works of the International Medical Conference Brussels-Novemember 1-4, 1962
Charles Richet; "Academie de Medecene", Paris, France.

The two most important medical points amongst deportees are on the one hand, their mortality in the camps, and on the other, the existence of sequels amongst many of them. Mans and ourselves have stressed the frequency of this and have indicated the clinical and pathologic features thereof. They are admitted by all the European clinicians. This notion of sequels is of particular interest to you in your capacity as doctors of prisoners of war. We have classified these sequels into precocius sequels, occuring one to twelve months after the return of the prisoners (tuberculosis, enterities, etc...); semi-retarded sequels, appearing between the 1st and 8th years (tuberculosis, rheumatism, stomach ulcer, etc...); retarded sequels, occuring sometimes after 15 years, the two most important of which, as they often involve death: are cardiac and nervous accidents.

The pattern amongst former deportees is, or was, very frequently as follows:

a. Diminution in occupational work capacity
b. Premature senescence (muscular, articular, cardiac, nervous, etc.)
c. Death, on the average, premature. We encounter confirmation of this latter point in Ellenborgen's statistics; in 1961, he lists only 0.7% over the age of 70 amongst former deportees.

DAVID - DOCTEUR EN MEDECINE - BELGIUM

It is obvious to anybody that certain diseases occur more frequently in former prisoners of war than in other people.

I have, personally, been able to ascertain a greater frequency of following diseases:

1. Digestive diseases, more in particular gastro-intestinal ulcers, sometimes concerised in its chronical form.
2. Cardio-vascular diseases, mainly of coronarian type.

Moreover, although my personal experience does not premit a valid statistic to be made up, I am firmly convinced, that one should add to this list T.B. mainly belated, and psycho-neurotic troubles.

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"PRISON-CAMP SYNDROME FOUND WIDESPREAD"
Haas: Medical World News 6:52-53; April 24, 1965

Permanent somatic and psychologic after-effects ranging from organic brain and

atherosclerotic damage to loss of memory and inability to function - are now being found increasingly among the more than 500,000 U.S. Citizens who suffered persecution and imprisonment by the Nazis and the Japanese during World War II. Studies in various world centers have also produced large-scale evidence of permanent and late sequelae that now affect prison-camp survivors.

While some physicians still maintain that protracted starvation and prolonged emotional stress produce no permanent physical or psychic damage, Dr. Ulrich Venzlaff of the University of Cottingen contends that "the results of experience in the camps of World War II have proved these doctrines untenable. We are dealing with serious psychic and somatic results of long-lasting extreme stresses."

"LASTING EFFECTS OF WAR"

From current clinical experiences with camp survivors, Wayne State's Dr. Henry Krystal reports that most of them suffer a marked reduction in general levels of functioning and a pronounced tendency to insomnia or nightmares. He notes the appearance of sequelae even among the 250,000 persons now in the U.S. who lived in wartime Europe without being interned. Many of these, according to Dr. Krystal, now show the effects of the starvation, disease, stresses and fears suffered during the years when they were forced to hide out.

New York University's Dr. Haas beleives that many symptoms found in former camp prisoners today are either mis-interpreted or overlooked in diagnosis. He urges physicians in private practice to acquire more information about the late sequelae of starvation and stress, so that they will be better able to recognize and manage these conditions.

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"THE CONSEQUENCES OF STARVATION"
The Medical Journal of Australia, Vol. II-52nd year, Sept. 1965, Pages 477-483

The most extensive experimental study of the effects of semi-starvation in man was carried out by a research team headed by Ancel Keyes at the University of Minnesota. Thirty-six fit young males, all volunteers, were screened by medical, psychological and psychiatric examinations before the experiment, but all developed neurotic symptoms during the second month of semi-starvation. (Keyes, 1950)

It is possible that long periods of semi-starvation may cause organic changes in the central nervous system. Independent reports from Denmark (Thygesen, 1965; Helweg-Larsen et ali, 1952), Norway, (Strom et ali, 1962) and Germany (Schulte,1953) have suggested that prolonged severe undernutrition may result in irreversible brain damage, with the production of permanent personality changes.

"OTHER BIOLOGICAL EFFECTS OF SEVERE STRESS"

In 1954, the United States Veterans Administration published the results of a follow-up study of ex-Servicemen, carried out by the National Research Council. Four random groups were investigated, each composed of 2,000 men. One group consisted of former prisoners-of-war from Japanese camps, one of former combat troops from the Pacific area, the third of ex-prisoners-of-war from Europe and the fourth of former combat troops from the European Theatre. The mortality rate and the incidence of illness in each group, in the six years after their liberation were proportional to the degree of under-nutrition and psychological stress to which the members of the group had been subjected. Thus, there was siven times as much illness among the Pacific prisoners, and twice as much among the European prisoners, as in either of the combat groups. The Pacific group had been imprisoned for an average of more than three times as long as the European group, and had suffered much greater hardships, including prolonged undernutrition. On the other hand, one may speculate that they were a highly select group, since they had survived conditions which had killed one-third of their comrades. However, it seems that they had aged biologically as a result of their experiences. Not only was their mortality rate almost three times the expected rate for their chronological age, but the incidence of almost every category of illness -- physical as well as psychological - was several times higher

among the Pacific prisoners-of-war than in any of the other groups (Cohen & Cooper, 1954).

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"LONG-TERM EFFECTS OF A PROLONGED STRESS EXPERIENCE:
V.A.Kral, L.H.Razder,M.D.and B.T.Wigdor,Ph.D. Concerning the Canadian Hong Kong Ex-Prisoners. Published in Canadian Psyciatric Ass.J. Vol. 12, 1967

STUDY RESULTS: The results suggest that the ex-POW's taken as a group are suffering from what clinically appears as a chronic depressive state, masked by tension and anxiety (5). They complain about nervous tension, anxiety, a feeling of depression, fatigue, slowness, sleep disturbance, some also about diminished sexual interest and potency.... In short, they present a picture similar to that frequently seen in former prisoners of concentration camps (6,1)

Whether this clinical picture is a psychogenis reaction of the accumulated severe stresses of three-and-a-half years' duration or whether it is the expression of organic brain damage, still remains an open question. However, the results of the Bender-Gestalt test are suggestive of possible early or mild brain changes that are impairing adequate functioning.

In addition, a significantly great number of the ex-POW group show signs indicative of impairment of the posterior funiculi of the spinal cord or the peripheral nerves or both.

Taking into account that the selection of our experimental group favored relatively healthy rather than sick subjects, one is forced to conclude that the three-and-a-half years of imprisonment in Hong Kong and Japan led to impairment of nervous functioning, even in individuals who in daily life are able to function adequately. Because of the multiplicity of stresses the subjects had to endure it is impossible to assess which of these stresses was mostly responsible for the present clinical picture, nor is it possible to express a definite opinion about the mechanism operative in its pathogenesis.

Previous experimental studies led to the conclusion that the homeostatic mechanism which enables the organism to withstand stress comprises nervous, particularly hypothalamic, as well as endocrine, particularly adrenocortical functions (2). It seems possible that under the impact of multiple severe stresses acting over a considerable length of time not only one, but all parts of the stress resistance mechanism might suffer long-lasting and even irreparable damage, although perhaps to a different degree.

Further studies on a larger material under controlled conditions utilizing special methods of investigation appear necessary in order to elucidate these important questions.

SUMMARY: A group of 20 ex-Hong Kong prisoners of war and a control group of 20 of their brothers who also had seen service in WW II, were investigated psychiatrically,

neurologically and psychologically. The results of this investigation are presented and discussed. It would appear that the accumulation of severe stresses endured over a period of three and one half years led to significant impairment in various areas of nervous and psychological functioning which is still easily detectable twenty years after liberation.

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"DELAYED DISEASE AND ILL-HEALTH"

A Sequelae of extreme stresses suring was and disaster.Published by the Norwegian Association of Disabled Veterans.Printed by A/S Teisen-Trykk,; Pages 22-75, 1969

"UNDERNUTRITION"

An undernourished organism is at a very vulnerable stage of adaption. Further stress will therefore easily lead to total breakdown. A supervening infectious disease as dysentery with diarrhea, other illnesses, physical efforts, cold or mental stress again and again proved to be the additional factor which resulted in serious clinical symptoms or even death (1,2). According to Seyle's stress theory, such new stressors will increase the tendency to arterial hypotonia, capillary dysfunction, fluid and electrolyte disturbances, edemas, etc.,and a vicious cycle may ensue.

In the long run, protracted undernutrition combined with infectious diseases and other stressors will lead to lasting damages in organs and organic systems as the brain and other parts of the nervous system, the liver, the pancreas, the heart, blood vessels, kidneys, skeleton and joints, endocrine glands, skin and muscles.

The German pathologist Wilke (3), by the way of introduction, says that the nervous tissue is not indifferent to prolonged under-nutrition and severe disturbances of the metabolism.

"AFTER-EFFECTS"

The ex-prisoners had little resistance to the postwar strain, due to wartime infectious diseases, injuries, premature aging, and progressive asthenia. To this must be added that they frequently found readjustment to social life difficult, and the more so with advancing years. (4). Among common postwar stressors may be mentioned: Nightmares, sleeplessness, lost educational opportunities, loss of social relationships, and excessive eating, smoking and drinking. (5)

Many signs of illness did not appear until after a long latent period. In reality no true restitution ever occurred. Small things could reawaken anxiety and terror reactions. As a consequence the symptoms appeared not solely at the time of the actual mental stress during the war, but often months or years later. This may perhaps explain the e.g. a heart infarct has been known to occur in connection with war horrors relived after years (6). Physical and mental frustration symptoms were particularly apt to make a tardy appearance, but might nevertheless be fairly marked, if the person in question had to face another failure, e.g. in his/her work or love life, or other difficulties. (5)

The first years after the war, there were relatively few reports on neurological disorders in former prisoners, but in the beginning of the nineteen-fifties reports of such finding started coming in with increasing frequency. This may be one indication that symptoms of nerve lesions have manifested themselves relatively late. Among factors leading to a worsening of neurological sequelae during the post-war

peroid mentioned: Age, liver and gastrointestinal diseases, defective absorption, misuse of alcohol, endocrine disturbances, degenerative disorders of the spine, vertebral artery insufficiency, and instability of the pressure in cerebrospinal fluid passages (7, 9, 2).

"THE CONCENTRATION CAMP SYNDROME"
(KZ Syndrome)

Eitinger (10) has later worked out a sharper delimitation of the concentration camp syndrome on the basis of the 11 symptoms most often demonstrated in Norwegian ex-prisoners on psychiatric examination, viz; 1)Failing memory and difficulty in concentration; 2)Nervousness, irritability, restlessness; 3)Fatigue; 4)Sleep disturbances; 5)Headaches; 6)Emotional instability; 7)Dysphoric moodiness; 8) Moodiness; 9)Loss of initiative; 10)Vegetable lability; 11)Feelings of insufficiency. A similar psychiatric symptomatology has been found in French (11) Polish (12) and American (13) former concentration camp inmates.

In another work, Archibald & Tuddenham (14) studied 62 veterans of World War II and 15 of the Korean War. In these, the authors found a syndrome of persistant stress reactions. Veterans who had combat fatigue continued to have combat dreams, blackouts, a tendency to hand and foot sweat, dearrhea, excessive irritability, headaches, depression, and they smoke excessively. The symptoms were frequently irreversible and tended to grow worse with the years. Seventy-five percent reported that their troubles prevented them from working, and 50 percent said their sex life was unsatisfactory. Thus, for many who had been expected to recover the ill-effects proved to be lasting.

Twenty years after the end of the war, the ex-prisoners - all with more than 3 years imprisonment - presented a number of psychic and neurological abnormalities which could not be demonstrated in their home-staying brothers. (15)

Besides the above reports, a number of studies on neurological late sequelae have been published in many countries (9,6). The most systematic examinations with a view to neurological delayed effects in concentration camp survivors have been carried out in Norway (7,9). Among former prisoners examined by the Medical Commission, diffuse encephalopathy has been a common find. Common mental symptoms encountered in the case histories were: Mental and Physical fatigability; retardation of mental activity; stereotype; emotional blunting; emotional instability; general narrowing of the range of activity; loss of initiative; personality changes; and mental depression. There moreover occurred headaches, nervousness, anxiety, hypersensitivity, feelings of insufficiency, introversion, dysphoria, character deviations, pseudopsychopathy, and abuse of alcohol. Taken separately, there was nothing specific about these neuro-psychiatric signs and symptoms.

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"STUDY PLAN & MORTALITY FINDINGS"

American Journal of Epidemiology,Vol. 91 Page 137, 1970. M.Dean Nefzger,M.D.: Follow-up studies of World War II and Korean War Prisoners.

Severity of stress during imprisonment, as indexed by survival, is inversely related to later survival in Korean prisoners. Lack of a difference in mortality between Pacific prisoners captured on Bataan or Corregidor can be reconciled on the grounds that any differences in their health at the time of capture were overshadowed by the events during more than three years of captivity. The contrasts between European prisoners generally and those admitted to hospital with malnutrition, and between European and Pacific prisoners, both suggest a positive association of stress with later mortality.

"MORBIDITY, DISABILITY AND MALADJUSTMENTS"

American Journal of Epidemiology, Vol.101, Page 421-1975. Gilbert W. Beebe, Ph.D.: Follow-up Studies of World War II and Korean War Prisoners.

Morbidity, some types of maladjustment, and disability all seem elevated in POW's relative to their controls, especially for PWJ's. If the screening period following repatriation is set aside (1945 for World War II POW's, 1953 for Korean War POW's), the most remarkable and long-lasting differentials are seen in the psychraitric area, especially in hospital admissions for psychoneurosis and for psychosis (schizophrenia). Scored responses to the Cornell Medical Index also suggest a fairly widespread affective disturbance among the PWJ's, especially. Although not high the hospital admission rate for psychoneurosis among PWE's shows that they did not go unscathed. Data obtained by questionaire on maladjustments support the conclusion that many PWJ's and PWK's have permanent psychologic impairment. Peripheral nerve (nerve ends) are also affected. (This was explained to me a Ph.D. to mean sensitivity. Do you know the difference between hot or cold? Hard or soft? Tickle or itch?

PWJ's.....Prisoner of War - Japan
PWE's.....Prisoner of War - Europe
PWK's.....Prisoner of War - Korea
Controls.....Men in the war in these areas but not prisoners.

DEFINITION OF ANY OF THE ANXIETY STATES

Ref: Diagnostic & Statistical Manual of Mental Disorders (3rd Edition 1980) American Psychiatric Association. (This will only be a partial list as I believe there are more).

ANXIETY STATES (OR ANXIETY NEUROSES) 300.01 PANIC DISORDER
The essential features are recurrent panic (anxiety) attacks that occur at times unpredictably, through certain situations, e.g., driving a car, may become associated with a panic attack. The same clinical picture occurring during marked physical exertion or a life-threatening situation is not termed a panic attack.

The panic attacks are manifested by the sudden onset of intense apprehension, fear, or terror, often associated with feelings of impending doom The most COMMON SYMPTOMS experienced during an attack are dyspnea; palpitations; chest pain or discomfort; choking or smothering sensations; dizziness, vertigo, or unsteady feelings; feelings of unreality (depersonalization or derealization); paresthesias; hot & cold flashes; sweating; faintness; trembling or shaking; and fear of dying, going crazy, or doing something uncontrolled during the attack. Attacks usually last minutes; more rarely hours.

A common complication of this disorder is the development of an anticipatory fear of helplessness or loss of control during a panic attack, so that the individual becomes reluctant to be alone or in public places away from home. When many situations of the kind are avoided the diagnosis of AGORAPHOBIA with panic attacks should be made rather than panic disorder.

ASSOCIATED FEATURES. The individual often develops varying degrees of nervousness and apprehension between attacks. This nervousness and apprehension is characterized by the usual manifestations of apprehensive expection, vigilance and scanning, motor tension, and autonomic hyperactivity.

AGE AT ONSET. The disorder often begins in late adolescence or early adult life, but may occur initially in mid-adult life.

COURSE. The disorder may be limited to a single brief period lasting several weeks or months, recur several times, or become chronic.

IMPAIRMENT. Except when the disorder is severe or complicated by AGORAPHOBIS, it is rarely incapacitating.

COMPLICATIONS. The complication of AGORAPHOBIA with panic attacks has been mentioned above, other complications include abuse of alcohol and anti-anxiety medications, and depressive disorders.....

GENERALIZED ANXIETY DISORDER may be confused with the chronic anxiety that often develops between panic attacks in panic disorder. A history of recurrent panic attacks precludes generalized anxiety disorder.

In simple or social PHOBIA, the individual may develop panic attacks if exposed to the phobic stimulus. However, in panic disorder, the individual is never certain which situation provoke panic attacks.

DIAGNOSTIC CRITERIA FOR PANIC DISORDER

A. At least 3 panic attacks within a 3 week period in cercumstances other than during marked physical exertion or in a life-threatening situation. That attacks are not precipitated only by exposure to a circumscribed phobic stimulus.

B. Panic attacks are manifested by discrete periods of apprehension or fear, and at least four of the following symptoms appear during each attack:

(1) Dyspnea
(2) Palpitations
(3) Chest pain or discomfort
(4) Choking or smothering sensations
(5) Dizziness, Vertigo, or unsteady feelings
(6) Feelings of unreality
(7) Paresthesias (tingling in hands or feet)
(8) Hot and cold flashes
(9) Sweating
(10) Faintness
(11) Trembling or shaking
(12) Fear of dying, going crazy, or doing something uncontrolled during an attack.

300.02 GENERALIZED ANXIETY DISORDERS

The essential feature is generalized, persistent anxiety of at least one month's duration without the specific symptoms that characterize phobic disorders (phobias), panic disorders (panic attacks), or obsessive compulsive disorder (obsessions or compulsions). The diagnosis is not made if the disturbance is due to another physical or metal disorder, such as hyperthyroidism or major depression.

Although the specific manifestations of the anxiety vary from individual to individual, generally there are signs of motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.

(1) MOTOR TENSION. Shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, and inability to relax are common complaints. There may also be eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle and sighing respiration.

(2) AUTONOMIC HYPERACTIVITY. There may be sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in throat, flushing, pallor, and high resting pulse and respiration rate.

(3) APPREHENSIVE EXPECTATION. The individual is generally apprehensive and continually feels anxious, worries, ruminates, and anticipates that something bad will happen to himself or herself (e.g., fear of fainting, losing control, dying) or others (e.g., family members may become ill or injured in an accident.

(4) VIGILANCE & SCANNING. Apprehensive expectation may cause hyper-attentiveness so that the individual feels "on edge", impatient, or irritable. There may be complaints of distractibility, difficulty in concentrating, insomnia, difficulty in falling asleep, interrupted sleep, and fatigue on awakening.

ASSOCIATED FEATURES. Mild depressive symptoms are common.

IMPAIRMENT. Impairment in social or occupational functioning is rarely more than mild.

COMPLICATIONS. Abuse of alcohol, barbiturates, and antianxiety medications is common.....

DIAGNOSTIC CRITERIA FOR GENERALIZED ANXIETY DISORDER

A. Generalized, persistent anxiety is manifested by symptoms from 3 of the following 4 categories:

(1) Motor tension: shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle.

(2) Autonomic hyperactivity: sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in throat, flushing pallor, high resting pulse & respiration rate.

(3) Apprehensive expectation: anxiety, worry, fear, rumination, and anticipation of misfortune to self or others.

(4) Vigilance and scanning: Hyperattentiveness resulting in distractibility, difficulty in concentrating, insomnia, feeling "on edge," irritability, impatience.

B. The anxious mood has been continuous for at least one month.

C. Not due to another mental disorder, such as a depressive disorder or schizophrenia.

D. At least 18 years of age.

300.30 OBSESSIVE COMPULSIVE DISORDER (or obsessive compulsive neurosis)

The essential features are recurrent obsessions or compulsions. Obsessions are recurrent, persistent ideas, thoughts, images, or impulses that are EGODYSTONIC, that is, they are not experienced as voluntarily produced, but rather as thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts are made to ignore or suppress them. Compulsions are repetitive and seemingly purposeful behaviors that are performed according to certain rules or in a stereotyped fasion. The behavior is not an end in itself, but is designed to produce or to prevent some future event or situation. However,

the activity is not connected in a realistic way with what it is designed to produce or prevent, or may be clearly excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist the compulsion (at least initially). The individual generally recognizes the senselessness of the behavior (this may not be true for young children) and does not derive pleasure from carrying out the activity, although it provides a release of tension.

The most common obsessions are repetitive thought of violence (e.g., killing one's child), contamination (e.g., becoming infected by shaking hands), and doubt (e.g., repeatedly wondering whether one has performed some action, such as having hurt someone in a traffic accident). The most common compulsions involve hand-washing, counting, checking, and touching.

When the individual attempts to resist a compulsion, there is a sense of mounting tension that can be immediately relieved by yielding to the compulsion. In the course of the illness, after repeated failure at resisting the compulsions, the individual may give in to them and no longer experience a desire to resist them.

ASSOCIATED FEATURES. Depression & anxiety are common. Frequently there is phobic avoidance of situations that involve the content of the obsessions, such as dirt or contanination.....

309.81 POST-TRAUMATIC STRESS DISORDER, CHRONIC OR DELAYED

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture) and others produce it only occasionally (e.g., car accidents). Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor amy be noted on axis IV.

The traumatic event can be reexperienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is reexperienced. In rare instances there are dissociative-like states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world, referred to as "PSYCHIC NUMBING" or "EMOTIONAL ANESTHESIA," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and secuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal sleep disturbances may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are often avoided. Symptoms characteristic of post-traumatic stress disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolize the

original trauma (e.g., COLD SNOWY WEATHER OR UNIFORMED GUARDS FOR DEATH-CAMP SURVIVORS, HOT, HUMID WEATHER FOR VETERANS OF THE SOUTH PACIFIC).

ASSOCIATED FEATURES. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an ANXIETY OR DEPRESSIVE DISORDER. Increased irritability may be associated with sporadic and unpredictable explosions of aggresssive behavior, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behavior can occur, such as sudden trips, unexplained absences, or changes in life-style or redidence. SURVIVORS OF DEATH CAMPS SOMETIMES HAVE SYMPTOMS OF AN ORGANIC MENTAL DISORDER, such as failing memory, difficulty in concentrating, emotional lability, autonomic lability, headache and vertigo.

AGE AT ONSET. The disorder can occur at any age, including during childhood.

COURSE & SUBTYPES. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after a latency period of months or years following the trauma.

When the symptoms begin within 6 months of the trauma and have not lasted more than 6 months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than 6 months after the trauma or last 6 months or more, the chronic or delayed subtype is diagnosed.

IMPAIRMENT & COMPLICATIONS. Impairment may either be mild or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or sympolizing the original trauma may result in occupational or recreational impairment. "Psychic numbing" may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Substance use disorders may develop.....

DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone. [The stressor in our case would be the POW experience. Stan]

B. REEXPERIENCING OF THE TRAUMA AS EVIDENCED BY AT LEAST ONE OF THE FOLLOWING:
(1) Recurrent and intrusive recollections of the event
(2) Recurrent dreams of the event
(3) Sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus.

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:
(1) Markedly diminished interest in one or more significant activities
(2) Feeling of detachment or estrangement from others.
(3) Constricted affect

D. At least two of the following symptoms that were not present before the trauma:
(1) Hyperalertness or exaggerated startle response
(2) Sleep disturbance
(3) Guilt about surviving when others have not, or about behavior required for survival.
(4) Memory impairment or trouble concentrating.
(5) Avoidance of activities that arouse recollection of the traumatic event
(6) Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.....

300.00 ATYPICAL ANXIETY DISORDER

This category should be used when the individual appears to have an ANXIETY DISORDER that does not meet the criteria for any of the above specified conditions.

MERRILL I. LIPTON, M.D.

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July 11, 1988

Doctor Merill I. Lipton was ready for medical school when he entered the Army in 1943. He was in the 14th Armored Division, 94th Cavalry Recon Squadron and went into southern France through Marseilles and drove north until Bulge time. He was a rifleman, PFC, also machine gunner on mounted patrols. They were cut off in a little village, Hatten, during January of 1945, it was below zero. On January 19th, he was hit by a close 155 shell, and left for dead in the snow by his friends. Two large chunks of shrapnel went through his head, almost lost an arm and both legs. After they put him in a litter, he was hit again by 88 fire from a tiger tank. It was two days before he was taken out to medical help, and he woke up in an Evac. Hospital five days later, did not remember anything that happened. Doctor Lipton spent two years in Halloran General Hospital getting major surgery every four to six weeks. He had eye and ear operations, having lost the use of the right eye and ear. Most of his forehead is a plate. He healed well, grew a lot of bone back, and has a fused knee.

Doctor Lipton started medical school in 1947, and went to Philadelphia in 1951 as an intern and there met his wife. He trained in psychiatry in Philadelphia and worked in the V.A. Outpatient Clinic in Philadelphia starting in 1960. Moved to Texas in 1980, and started working at the Temple V.A.M.C. He was soon working with Post Traumatic Stress Disorder, since he experienced personal PTSD problems for years, even while in medical school, and found ways to deal with it on his own. (In those days you didn't admit to the problem.) The first PTSD group started in 1981, and since then he has treated many individuals, many of them ex-POWs.

He retired from the V.A. in September 1987 and has a private practice. However, he still return to the V.A. groups two afternoons each week.

Doctor Lipton and his wife have six children, five married and a twenty year old in college.

POST TRAUMATIC STRESS DISORDER IN THE OLDER VETERAN

by Merrill I. Lipton, M.D.

June 1988

In the V.A. Hospital here in Temple, Texas, the diagnosis of PTSD was made mostly for Vietnam Veterans. However, early in 1981, we evaluated a number of WWII and Korean Veterans who appeared to have this diagnosis. When a sufficient number of these older veterans expressed interest, we started the first weekly group in November 1981. Starting in January 1983, a second group was started. Both groups continue to meet weekly. We will try to review our experience.

Evaluation of PTSD in WWII and Korean Veterans presents a number of problems. The first is our own bias, since the diagnosis is rather new and the literature mainly relates the evaluation and treatment of this problem to younger Vietnam Veterans. In addition, post WWII psychiatric residents usually learned that "combat fatigue" and nervous reaction in combat were related to pre-existing psychopathology. This influenced our attitudes. Many veterans became S.C. for their in-service diagnosis of "anxiety neurosis" or variations such as "neurasthemia". In the past, when we saw a veteran who had been service connected for anxiety or depression over the years,, we inquired into their usual symptoms. Inquiring into symptoms of PTSD was simply never a consideration.

We have now found that older veterans are usually very reluctant to talk about their problem. They deny symptoms, even when asked specific questions. We found that talking about our own service and combat experience often enabled the veteran to admit to some experiences and symptoms. Relating our experiences with his peers in the post traumatic group was likewise helpful. One man, for example, remained very upset on a psychiatry ward for three months despite medication and psychotherapy. His interview with us gave the first indication that PTSD was the underlying problem. This man finally admitted to combat nightmares, daytime ruminations, and numerous other symptoms of the disorder. His symptoms subsided fairly rapidly after he joined the group.

Planning the first group required a number of choices and decisions. We chose the name, "Traumatic War Neurosis Group". to avoid diagnostic working that could raise the issue of service connection. A name like "Post Traumatic Stress Disorder Group" could imply to some that we believed group members to have this diagnosis and, therefore, entitlement to compensation. We naturally made it clear from the beginning that the group was formed to help with problems and was not related to the issue of service connection.

The group was made available to combat vets and ex-POW's age 40 and over. We chose this age because the Vietnam Group was already meeting weekly and had no members over 35. In addition, we understood that the older veterans from Vietnam saw themselves as different from the young ones.

Prior to starting the first group we handed out, "Group Guidelines", indicating the purpose of the group, that we would meet weekly for one and a half hours, that any problem could be talked about, but we would focus on combat and POW events and why certain memories keep coming back, and would also discuss current problems of adjustment for group members. The guidelines also indicated that threats and violence would not be tolerated and would be cause for dismissal from the group.

Results in the two described groups have been dramatic. All group members were feeling better and getting relief of symptoms quickly, usually by the third or fourth meeting. Most group members continued to improve, reporting changes like improved sleep, lowered anxiety and depression, fewer nightmares and daytime ruminations, improved social comfort and increasing social activities, and better relationships with their wives.

In the group we often discussed the single most recurrent memory for an individual. This included his relating the details of the events and his feelings and guilts about it. Other group members could relate through similar events in their own experience and give the individual feedback. For example, one individual relates a combat incident in which one or more of his comrades were killed. He feels very guilty because it would not have happened had he done something different. Group members whose opinions he respects tell him he did the right thing, he had no way of knowing what would happen. Worrying what you might have done or should have done differently is recognized as a losing approach. One must learn to accept that he did the best he could under the circumstances, and it must stop there. We may go back to one individual's incident several times over a period of months. Present day problems can take up some group sessions entirely. We talk about things like medical concerns and problems, marital and family problems, employment problems, veterans benefits, or world affairs. This group of veterans is very patriotic and get upset at disrespect of the flag or disrespectful incidents that occur abroad and reflect on national pride.

The combat subjects discussed can be very upsetting to individuals in the group. We warn them beforehand that going back to deal with "unfinished business" is difficult. Hopefully, doing this will enable one to spend less total time with the memories during the remainder of the week. Although this has generally held true, some group members reported a couple of bad days after each meeting, with more nightmares and tension. Although this generally subsides after a couple of months some individuals continue with the problem longer. In our experience, only two individuals terminated the group and opted for individual visits because of this problem. Quite a few individuals refuse to join the group, indicating they could not tolerate reminders that serve to stir up symptoms.

A review of our experience confirms that PTSD is more common with torture and with CNS damage (malnutrition), since a higher percentage of ex-POWs appear to need help with PTSD symptoms. Dissociative-like states are also frequently reported by group members, who pass exits on the highway or have near accidents while driving. In many instances a shout from their wife helped a number of people "snap out of it" in

time to avoid a collision. This is another problem we have heard more commonly from ex-POWs. Such episodes are often triggered by an environmental stimulus like a familiar view, sound, etc. At times they start during a period of rumination. Some individuals found themselves in distant cities, not knowing how they got there.

Most group members continue to re-experience traumatic events either in nightmares or in daytime ruminations, or both. A number of individuals feel guilty about injuring their wives during nightmares, and many wives sleep in another bed and often in another room. Most of the time the wife has moved to another room on the insistence of her husband, who is concerned about hurting her again. Wives usually learn quickly that they can help their husband by awakening him from the nightmare, and they must also learn how to accomplish it safely, so as to avoid injury. Many of these veterans take a few moments after awakening to fully recognize where they are. Most of the veterans we deal with keep a light on all night to help this problem of disorientation upon awakening, which is a frightening experience.

Daytime ruminations of wartime events are also very common for group members, and at times lead to dissociative-like states already mentioned. We also learned of instances where an ex-POW who remained in service was assigned by error to duty in the country in which he was held prisoner. There he had dissociative-like episodes in which he usually assaulted individuals who looked like his former guards and tormentors. One man, for example, was suddenly astride his victim, and would have smashed his head with a hammer if not for the quick action of others nearby.

We often discuss the nightmare problem and advise that people tend to dream about the things that were on their mind during the day. Therefore, keeping thoughts of wartime incidents to a minimum during the day can help reduce nightmares. This gives people something specific they can do to control the problem, and the feeling of control is important. In addition, medication is often helpful in reducing the frequency and severity of nightmares. Many group members have been helped by anti-depressants. We, therefore, feel that the combination of group therapy and anti-depressant is very effective in the control of combat nightmares, and the relief is often dramatic.

Another common complaint for group members has been a numbing of response or "emotional anesthesia" and inability to get close to others. Discussions have led to additional understanding of these feelings of detachment. Many group members can recall events during which they were numb to events going on around them. They were aware at some level, yet were not aware of the horror going on around them. A man would say during this discussion, "I saw it, but I didn't see it". This numbing appears to be a common defense mechanism during such overwhelming stress. After long periods of combat or POW stress, most individuals appear to use the numbing mechanism automatically and habitually. The habit can be hard to break, so that after the war, friends and relatives see a change in personality. The individual who was previously warm, friendly and sociable has become cold, distant, and not sociable, and unable to express feelings of love and tenderness.

intense psychological distress at exposure to events that resemble or symbolize an aspect of the event-loud noises or the death or departure of a loved one.)

3) Persistent avoidance of stimuli associated with the trauma or a numbing of general responsiveness. (Such as not thinking about what happened, denying that it occurred, hiding out on the Fourth of July, inability to express love, a sense that there is little future - it doesn't matter I should have been dead a long time ago.)

4) Persistent symptoms of arousal that were not present before the trauma. (Difficulty sleeping, outbursts of anger, difficulty concentrating, always on the alert- like the back row on the isle in the theater or along the wall and near a door in a restaurant.)

5) The symptoms have persisted for at least one month. If the symptoms appear at least six months after the trauma the condition is said to have a delayed onset. And generally, in medicine, any condition which persists for more than a year is said to be chronic.

If PTSD were a shoe, I think you can see that to a greater or lesser degree, it would fit most of you- not comfortably because that's not the nature of the thing.

You would think that with the criteria so clearly outlined it would be easy to make the diagnosis, but there is a quirk in the thinking of many of us (often unrelated to the criteria described above) and in many of the doctors and mental health professionals for whom we turn for help in the VA system. This quirk has been expressed as Dr. Roger Pitman who is with the VAMC at Manchester, New Hampshire and a professor at the Dartmouth Medical School. He said, and this is not a direct quote, "Time does not heal all wounds. We do not expect time to heal defects, but we do expect it to heal wounds. Hence, when a psychological wound does not heal, we may be inclined to believe that it actually represents some kind of defect. This accounts for much of the resistance that the diagnosis Post Traumatic Stress Disorder has encountered prior to and following its introduction in 1980 (with DSM III).

Many mental health professionals, I'm sorry to say, feel that a person doesn't develop mental or emotional problems unless there is some defect in that person's development. Others feel that the development of mental or emotional problems is in some way the fault of the individual who develops the problems. Under ordinary circumstances there may be a grain of truth in that thinking, but in relation to "events beyond the range of the usual human experience" that is simply not true. Yet, not only some mental health professionals, but some of us also believe it to be true and we have a sense of embarrassment and of not wanting anyone to know or see that we jump at loud noises, that we sit on the isle, or that we sit with our backs to the wall, or that we dread the coming of night with the sweats and dreams that it brings. And we have lived with this and other such things for forty, thirty, twenty or ten or more years, depending on when we served. Often our wives and children know about these things that may puzzle and hurt them but they are not going to tell on us.

You should recognize and understand that any one, no matter how strong, if placed under enough stress is going to develop symptoms. And the intensity and duration of these symptoms is proportional to the intensity and duration of the experience. So there is actually nothing to be embarrassed when one recognizes such symptoms in oneself. Remember what Dr. Will Menninger said-these are normal reactions to abnormal situations.

After combat, which is capable of producing PTSD, came the captivity and the imprisonment. Imprisonment is capable, in its own right, of producing PTSD, but the effects of imprisonment can go beyond PTSD. One of my favorite writers, John Creasy, an Englishman, wrote in his book, "The Toff and the Great Illusion", "It wastes you; it wastes your mind and your body, it makes you into a machine, it let's you see yourself withering away, but it doesn't kill the image of what you once were." John Creasy was writing about civil imprisonment but, it seems to me, the same thing can be said about the POW experience.

In addition there is another factor which, through known for some time is not yet fully considered in the POW protocol and in considering the possible long term effects on former prisoners of war. Possibly because it can be a subtle thing to recognize even when the professionals are aware that it exists. This is the condition often referred to as the K-Z Syndrome. Roughly translated the K-Z Syndrome means the concentration camp syndrome.

Boydston and Perry in the Third Edition of the Comprehensive Textbook of Psychiatry wrote as follows: "It is common for a victim to lose 30 to 40% of body weight during captivity, and several studies have shown a definite positive correlation between the amount of body weight lost and subsequent disability. This disability is thought to be the direct result of famine, with protein, vitamin, trace minerals and other nutrient deficiencies causing impairment of the immune mechanisms and wasting of brain, myocardium, and other tissues. Enduring mental reactions are common, but it is usually impossible to sort out the somatic, vegetative symptoms from the purely psychological symptoms.-----These symptoms may range from mild to severe and may manifest immediately or have an onset many years after a period of latency."

"These symptoms occur in from 85% to 43% of the victims and in rank order are: increased fatigue, nervousness-irritability-restlessness, memory impairment, dysphoric mood, emotional instability, sleep impairment, anxiety, feelings of insufficiency, loss of initiative, headache, and vertigo.

"The Scandinavian countries have legislated entitlement to compensation for K-Z disability, but in this country it is still a disputed quagmire, and generally, compensation is contingent upon a more precise diagnosis such as organic mental disorder or depressive disorder.

Because the diagnosis of K-Z Syndrome depends upon a constellation of symptoms, including history, and not upon a few symptoms, such as organic mental disorder or depressive disorder and because it

is difficult, if not impossible to prove what conditions were 20 to 40 years ago, the diagnosis of K-Z Syndrome is almost impossible to establish for purposes of compensation, if it is not legislated as in the Scandinavian countries. Then, too, the nature of the symptoms are such that it is easy for mental health professionals to classify a person displaying these symptoms as malingering, of attempting to get something for nothing. Since many of the PTSD and K-Z symptoms are associated with emotional, affective experiences, it is hard, if not impossible for many people, including many mental health professionals to understand much of the driving force behind the symptoms. Trying to explain the emotional content of these experiences to people who have not been there is like trying to describe the color of an object to a person who has never seen a color. Or, if such persons are sensitive enough to understand at least part of the horror involved they often turn away, revolted by what they hear, thrusting the experience and often the POW from their awareness. And who can blame them, for many of us have tried for years to thrust the experience from our lives. It is harder for the POW to thrust it out because he has not only heard about it has lived it and the experience is embedded in his body as well as his mind.

The third whammy - the effect on the families of the POW have been most closely studied in a somewhat similar population, the concentration camp survivors. Probably one of the most common problems is the inability of the POW to allow himself/herself to become involved in close, intimate, interpersonal relationships. That is not to say that the POW doesn't want to be emotionally close to his/her family, but he/she knows, without knowing he/she knows, from earlier experiences that if he/she cares enough about someone, if he allows himself/herself to get close to someone, or that someone to him, something bad is likely to happen that person, that person is likely to suddenly disappear from his/her life. The pain of the loss is more than he/she wants to accept and so many POW relationships have in them a quality of distance, of not quite touching or being touched by those around him/her. And this is sometimes reflected in the wives and children. They have adjusted to this distancing in someone they love and this distancing carries over into their relationships with others.

I have seen some of my fellow POWs so driven by this fear that when they experienced themselves as getting too intimate with their wives and children they would hop in their cars and drive around visiting their fellow POWs, making sure they were alright before going home once more to their families. These actions are usually laughed off,"I guess it's about time for old so and so to make his rounds again."

A terrible thing about this attempt on the part of the POW to unconsciously protect himself/herself and his family from hurt is that, like many of the ways people protect themselves psychologically it doesn't really make sense. It is based on assumptions that are not true. Loving and holding someone doesn't mean that someone will be hurt or die - unless, of course, you have had someone die in your arms - and then it can seem to be true.

Another unsettling thing about relating to family and friends by

distancing is that calamities do befall people, calamities over which you have no control in spite of your best efforts to protect others. When the calamity happens you blame yourself. You haven't take good enough care of them, haven't done enough. You feel guilty as hell. It doesn't take much effort to figure out where that feeling comes from. From the time when calamities happened in spite of all you could do, and you tried to still the horror of it and to keep a sense of control in a situation not subject to control by saying , "If I'd only done a little more things would have worked out.

Remember what Dr. Will said about normal reactions to very abnormal situations. Those reactions helped us to not go insane in insane places. And often, without being aware of it, because they helped us in those situations we think they may help us now. Not so, those psychological maneuvers which protected us then only get in our way now. Let us turn briefly to the treatment of these conditions.

First, there must be the recognition on the part of the POW that his/her life could be better if part of the burden of the PTSD and K-Z were carried by someone other than himself/herself and their family. This means a willingness to share the experience with the professionals who have indicated a desire and have the expertise to help. This probably takes an understanding, or belief, on your part that what you are experiencing, have experienced could happen to anyone under similar circumstances. Remember what Dr. Will said.

Second, you must be willing to trust the professionals to know what they are doing. I know that can seem risky but you have taken risks before.

Third, there are currently medications which can be helpful with the psychological symptoms.

Fourth, there are medications which can be helpful with the physical symptoms.

Fifth, ask that those close to you, particularly your wife be allowed to participate in whatever process the professionals recommend. They, too, have been bruised by what happened to you and they have earned the right to share in the healing process.

Sixth, recognize the VA was created to help veterans. Having worked some for the VA and consulted to it for a number of years, I know the people who work for it are by and large caring and compassionate people. Certainly you will occasionally run into some smart-assed character who never spilled any of his blood for his country and whose mother walks three times around her chair before sitting down. When that happens, if you feel strongly enough about it, let the POW Coordinator know. You may never see or hear anything about your complaint. That can be frustrating, but I can tell you that in most VA hospitals, the boss man doesn't want any complaints about a staff member not doing his job, so he's going to check it out. Just be sure your complaints are legitimate and that you have the facts about what happened.

Seventh, support your POW and veteran organizations. The VA is a huge federal organization and has to respond to many demands both from Washington and from the country's veterans. The voice of one person can easily get lost at the national level, but the voice of you AND your comrades in arms is much less likely to get lost. Then, too, there is a sense of comfort in sharing activities with people who have something in common.

Eighth, keep in mind what you already know, that life isn't easy and nobody ever said it was fair. however, we can all work together making it, if not easier, at least more fair.

I served my combat time as a 2nd Lt. in the 92nd Philippine Scouts,a small regiment of about 600 men at the time the war started. The regiment was commanded by Colonel Octavius DeCarre, a combat veteran from WWI. He was serving his last post before retirement when Pearl Harbor was bombed. When the "situation was fluid" as the shortwave radio from the States used to say, which meant that we were getting kicked around pretty good, he would make the rounds of his various units to say a few words to his officers and men. I cannot quote the Colonel directly, but the substance of his remarks was essentially always the same.

The situation is not the best. (We were pretty much aware of that.) It will probably get worse. (We were pretty much aware of that.) However, you are American soldiers and you are still breathing. (We were aware of the first part. Some of us were not so sure about the second part.)

So, if you are breathing you can always take one more step and fire one more shot. When you stop breathing it won't matter to you but it can make a difference for those who come after you. So let me take a page from my Colonel's drill book.

There are times, particularly as we age and things don't seem to work like they once did, when "the situation is fluid". But remember that at this moment all of us are breathing so we can take one more step and take one more shot, as we try to convey the meaning of the POW experience and the consequences of the POW experience to those around us. It may not do a lot for you and me but if, and knowing human nature it may happen though God forbid it does, there are others who come after us who have to go through the same experience, perhaps we can contribute something to ease the path for them.

So take a deep breath, load your weapon, step out and take your best shot for yourself, your families, your buddies, and those who may come after us. It is easier now than it was long ago because, though it may not always seem that way, we are not in hostile territory but among friends.

Thank you for your time and attention.

PSYCHOSOMATIC & STRESS DISORDERS IN WW II PRISONERS OF THE JAPANESE

by Clarence E. Carnahan, MD; Harold C. Morris, MD
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ABSTRACT: PUBLIC LAW 97-37 DEFINED PRISONER OF WAR STATUS AND ESTABLISHED VA ELIGIBILITY CRITERIA FOR FORMER PRISONERS OF WAR. SINCE THE ENACTMENT OF THIS LAW IN 1981, THE VA HAS EVALUATED AND TREATED INCREASING NUMBERS OF THESE FORMER PRISONERS. THIS ARTICLE SURVEYS THE PHYSICAL AND EMOTIONAL CONDITION OF 41 AMERICAN MEN WHO WERE PRISONERS OF THE JAPANESE FROM 1941 TO 1945. EXAMINATION OF THESE FORMER PRISOENRS REVEALED MANY OF THE LONG-TERM EFFECTS OF EXTREME STRESS AND MALNUTRITION. THE STRATEGIES THESE MEN USED TO SURVIVE CAPTIVITY AND 40 YEARS OF REINTEGRATION INTO SOCIETY ALSO WERE STUDIED.

SUMMARY: THESE MEN HAVE SURVIVED COMBAT, PRISON, PHYSICAL AND MENTAL TORTURE, MALNUTRITION, REENTRY INTO SOCIETY, AND THE SUBSEQUENT 41 YEARS OF LIFE. ALL WERE ON THE BRINK OF DEATH AND MADE A DECISION FOR LIFE. SUBSEQUENT TO THEIR POW ORDELAS, THEY HAVE HAD A SUBSTANTIAL NUMBER OF PROBLEMS - SOCIAL, MARITAL, PHYSICAL - AND MOST OF THESE RESIDUAL PROBLEMS RESULT FROM POST-TRAUMATIC STRESS. THEY HAVE MANAGED TO LIVE, AND EVEN THRIVE, DESPITE THESE RESIDUALS. NOW AT RETIREMENT, THEY ARE FACING NEW ADAPTIVE CHALLENGES BECAUSE THEY CAN NO LONGER USE COMPULSIVE WORK TO COPE. AGAIN, THEY ARE SEEING THEIR BUDDIES DIE. THEY ARE FINDING STRENGTH TO SURVIVE THIS STRESS BY MEETING AND SHARING THEIR COMMON EXPERIENCES AND INTERESTS. THE USE OF FORMER POW VOLUNTEERS IN THE TREATMENT PROGRAM HAS BEEN A TREMENDOUS ASSET AND HAS MADE THE TREATMENT EXPERIENCE LESS IMPERSONAL.

THERE HAS BEEN A DRAMATIC INCREASE IN THE NUMBER OF FORMER POWs WHO HAVE SOUGHT TREATMENT FROM THE VA. SOME HAVE COME IN RESPONSE TO PUBLIC LAW 97-37, OTHERS BECAUSE THEY HAVE REACHED RETIREMENT AGE AND ARE EXPERIENCING BOTH PHYSICAL PROBLEMS AND ADJUSTMENT DISORDERS. FROM THESE MEN, SOCIETY CAN LEARN LESSONS ABOUT HOW THE HUMAN MIND, BODY, AND SPIRIT CAN WITHSTAND UNBEARABLE CIRCUMSTANCES. FURTHER RESEARCH CONCERNING DISORDERS RELATED TO IMPRISONMENT DURING WARTIME MUST BE UNDERTAKEN SO THAT EFFECTIVE INTERVENTION PROGRAMS CAN BE ESTABLISHED.

OF THE 41 FJPOWs EXAMINED - PRESENT GENERAL PROBLEMS WERE:

39 DEPRESSION	36 BURNING FEET
36 NIGHTMARES	33 ANGER
34 SWEAT ATTACKS	31 STARTLE REACTION
31 ISOLATION BEHAVIOR	29 SEXUAL PROBLEMS
19 VISUAL PROBLEMS	39 BONE, JOINT, & BACK
30 HEART DISEASE	25 PEPTIC ULCER DISEASE
24 NEUROPATHY	18 IRRITABLE BOWEL SYNDROME
7 MALIGNANCY	4 LIVER DISEASE

IT WAS A PLEASURE FOR POW MEDSEARCH TO CONTRIBUTE RESEARCH FOR THIS PAPER.

POST TRAUMATIC STRESS DISORDER AND THE POW

by Robert L. Obourn, M.D.

Presented at Ex-POW MedSearch Seminar, DAV Building
Kansas City, Missouri
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Robert L. Obourn, M.D. studied pre-med at Washington University in St. Louis, Missouri and was in ROTC for four years while an undergraduate. He was scheduled for medical school in the fall of 1941 but was called up in June and received his orders to active duty about a half hour after receiving his diploma. He was sent to Fort Bliss, Texas and then to the Philippines where he was assigned to the 92nd Scouts as a Second Lt. and fought with them.

Doctor Obourn was a POW of the Japanese for three and one-half years. He was held prisoner in the 92nd Garage, Bilibid, and Cabanatuan in the Philippines and then in Yodogawa in Osaka, Japan. After our forces began to bomb Osaka he was sent to Oeyama at Miazu on the west side of Honshu, Japan.

After the war he returned to medical school and graduated in 1950. He took his internship at Fitzsimmons Army Hospital in Denver, Colorado and was in general practice as a country doctor in a small Kansas town for about thirteen years. Doctor Obourn then took his residency in psychiatry at the Menninger School of Psychiatry in Topeka, Kansas, after which he stayed at the Menninger Foundation until his retirement in 1984 at which time he was Director of the C.F. Menninger Hospital.

Doctor Obourn came out of retirement and worked at the VAMC in Topeka. At present he works part time as a consulting psychiatrist. He is an eminent physician and a foremost leader in the field of psychiatry.

POST TRAUMATIC STRESS DISORDER AND THE POW

A war isn't over because the bands stop playing. Many veterans spend their post war years inching through life on their way to becoming a statistics in a mortality table. If one takes out of the veteran pool those veterans physically and obviously wounded and those who cracked under the strain of battle and /or imprisonment, there is left a group whose wounds are less easily recognized, whose wounds of the mind may or may not heal. And if the wounds heal, there are often left scars which inhibit and handicap these veterans, subtlely or not subtlely for the rest of their lives. These are the wounds which the veterans themselves, their wives, their children, and their government often refuse to recognize. Yet these are wounds for which all pay a price; the veterans, their families, and friends in emotional turmoil and strain and the government through legislatures in money, puzzlement, bewilderment, frustration, and eventually anger, not toward the war, the pain and the suffering, the captivity but toward and about the veteran.

I have been asked to talk today about those often hidden psychic wounds, about a condition which is currently labeled Post Traumatic Stress Disorder. This condition is not peculiar to veterans alone but is found in other walks of life and in other groups of people. However. today I will talk about Post Traumatic Stress Disorder in veterans who, as we will see, have been hit by circumstances which lead to unusual trauma of mind and emotion, to the soul and to the physical being. These veterans, to put it in slang language, have been hit with a double, triple, and often quadruple whammy.

The first whammy is combat and most POWs are combat veterans or they wouldn't have been captured in the first place. The second whammy is the prison experience. The third whammy is what happens as the result of whammy one and two, the effect on the wives, the children, the immediate families of the POWs. The fourth whammy is the deterioration of the physical condition brought about by the ongoing, chronic psychic stress which caused changes in the body's various defenses against physical illness and leads to the development in the POW of a group of illnesses often called "psychosomatic", but which are now know officially as "psychophysiological reactions"; such illnesses as peptic ulcer, asthma, arthritis, and an increased susceptibility to diseases of various types.

John Caldwell in the First Edition of the Comprehensive Textbook of Psychiatry says, "The problem of emotional disorders has plagued the military since the beginning of recorded history." In the Seventh Chapter of Judges a procedure for the selection of men "fit" for combat is described. Israel and Midian were preparing for battle and the Lord told Gideon how to select his men for battle. There were 32,000 men who were "drafted" and that number was finally reduced to 300 who defeated the Midianites. Caldwell says that the reduction from 32,000 to 300 men does not seem out of line with current figures concerning psychiatric casualties of modern war.

The Third Edition of the Comprehensive Textbook of Psychiatry discusses the history of Post Traumatic Stress Disorder under the heading of "Traumatic War Disorders">

In the Civil War (1861 to 1865) emotional disturbances were called "nostalgia" and were thought to be caused by the soldier being away from home. Also in the Civil War there was described a set of circumstances called Camp's Syndrome in which there was an increased heart rate and the soldiers complained of heart trouble in the absence of objective signs of heart disease.

In the Russo-Japanese War (1904 to 1905) the Russians used the terms "hysteria" and "neurasthenia". This appears to be the first description of "war neurosis" as such.

In WWI (1914 to 1918) British and French military doctors used the terms "war neurosis" and "shell shock".

In WWII (1939 to 1945) the terms "psychoneurosis", "anxiety state", "mixed psychoneurosis", and "conversion hysteria" were used to described the Traumatic War Disorders. In 1943 the term "combat exhaustion" was used to describe a transient psychological breakdown in persons with or without a neurotic predisposition. This appears to be first recognition that could produce illness in previous healthy people. Dr. Will Menninger from Topeka, who was at that time a Brigadier General and part of a study group on the psychological effects of war, stated that the Traumatic War Disorders did not result from the individual in some way being flawed, having some kind of a defect, but were the normal psychological reactions to very abnormal situations. This statement by a very clear think "local boy" made some forty-five years ago got lost in the many theoretical discussions by psychiatrists following WWII and only recently is this statement once again beginning to receive some acceptance but without, I think, proper recognition for the man who first said it.

In 1980 the American Psychiatric Association published the Diagnostic and Statistical Manual, Third Edition. This book is commonly called DSM III. It is rather like a guidebook to psychiatric conditions and has a strong influence on the way mental health professionals diagnose and think about mental and emotional illness. The DSM III has recently been revised and will probably be revised again. In DSM III the Traumatic War Disorders have been placed in a category called Anxiety Disorders under the sub-heading of Post Traumatic Stress Disorders. This sub-grouping covers not only the Traumatic War Disorders but also disorders arising from such catastrophes as fire, flood, rape, hostage situations, and other natural and man made disasters.

The criteria for thee diagnosis, as given in DSM III R, I will state in a markedly abbreviated form, but enough to convey an idea of how Post Traumatic Stress Disorder is diagnosed.

1) The experiencing of an event that is outside the range of the usual human experience and that would be distressing to almost anyone. (I think that both combat and the POW experience fit that criterion.)

2) The traumatic event is persistently reexperienced.(Such as recollections that intrude into one's thoughts, recurrent dreams of the event, sudden acting or feeling that the event is recurring,

One ex-POW gives an interesting and dramatic example of shutting out his chaotic surroundings. He describes how he would lie on the ground when he had the opportunity, cup his fists and look up at the sky. All he could see would be bits of blue sky, and he concentrated on that. This was his way of temporarily shutting out the horror surrounding him in the prison camp.

We often hear in the groups about an additional factor making for social aloofness and the apparent personality change. After being upset repeatedly in combat when friends were injured or killed, they attempted to avoid friendships and closeness to others. This applied particularly to replacements, who were often injured or killed in a short time because of their lack of experience. Emotionally distancing one's self from others in this way became a habit that was also hard to break. Loss of ability to become interested in previously enjoyed significant activities is another problem we often hear from group members. Hunting is probably the most frequent example. Prior to service, most group members were enthusiastic hunters. With few exceptions, this activity was completely abandoned. The usual reasons given are strong feelings against killing living things and startle reactions to the sound of gunfire. We occasionally hear a remark about deer hunting like, "It's too much like an ambush".

We hear from most group members about symptoms of excessive autonomic arousal. Exaggerated startle response is very common, but varies in intensity. For some it has gradually diminished in intensity over the years. For others, a door slam or a pot dropped in the kitchen causes a severe reaction and gradual recovery, usually within a few minutes. A few have the problem with silence, and they warn family and friends not to come up behind them without some warning. They fear they will automatically attack and hurt someone who acts like they are sneaking up behind. This probably represents a type of hyperalertness. We have not seen many problems of generalized hyperalertness, in which one might walk the streets maintaining constant vigilance.

Sleep disturbances are very common in the groups, with difficulty in falling asleep, frequent awakenings, and terminal problems. A nightmare is a frequent reason for staying awake for the remainder of the night. Sleep has usually improved with group therapy and medication. One ex-POW who was awakened numerous times every night is now able to sleep through many nights without a nightmare. However, he continues to have nightmares in which he starts shouting and screaming, and his wife must awaken him. There are still nights when this happens repeatedly. He is pleased by the improvement, even though some of the problems persists.

When group members feel comfortable enough to talk about it, they all have strong guilt feelings about their experiences. The most intense guilt usually relates to feelings that at crucial times they did not fully do their part or what they should have done, or should have done better. This type of guilt relates to a friend getting killed or other undesirable events they feel they could have, or should have, changed. They say that if they had done this or not done that, things would have been different. They also feel guilty about being frightened at crucial times, and not measuring up to the "John

Wayne image". Along with this, they feel guilty about surviving when their friends and comrades did not. There is even guilt about getting injured, which takes you away from your friends under fire, guilt that you are not doing your part. This relates to talk of "the million dollar injury" in combat, which is an arm or leg injury serious enough to require medical evacuation. One then feels guilty about having such forbidden thoughts or wishes.

Another guilt is that of ex-POWs who all somehow feel guilty about getting captured. Capture relieves you of the need to face combat, implying that people get captured in order to avoid doing their duty in combat. (This guilt is obviously intensified by the forbidden wish.) An infantryman who was surrounded and captured after many of his friends will say, "I could have fired and maybe got one or two, but I would have been mowed down". He says this defensively, like he must make an excuse for not fighting to the death. The flier who was shot down over Germany and taken captive also expresses guilt, says, "I should have tried to escape". This is expressed even by a man who was injured in a parachute jump and surrounded by angry farmers with pitchforks. The men who were captured on Corregidor all express anger, saying they were still ready and willing to fight but were ordered to surrender.

The guilts are handled in groups by discussions of the realities. These include reassurance that fear is "normal" in such circumstances, they did their best under the conditions, and one must accept his best as good enough and not expect more of himself. Having been in similar circumstances, group members can reassure one another in these matters. This helps to leave the past behind.

— NOTES —

PSYCHOLOGICAL EFFECTS OF PRISONER-of-WAR EXPERIENCES

GAYLE K. LUMRY, Ph.D.

The purpose of this paper is to review the literature available to support Dr. Leslie Caplan's thesis that all veterans who have been subjected to prisoner-of-war experiences ought to receive service-connected disability automatically. This conviction of Dr. Leslie Caplan, a Minnesota psychiatrist, stemmed from his own prisoner-of-war experiences in Germany as the only physician to provide medical care for 2600 prisoners who were forced to march 600 miles during mid-winter with inadequeate clothing, practically no medical supplies, and low-quality food rations of only 800 calories a day.

PHYSICAL EFFECTS of PSYCHOLOGY STRESS

Such extremes of severe psychological stress and physical deprivation may leave prisoners of war with degrees of systemic disability not readily detectable in ordinary physical examinations. As continuing effects Dr. Caplan cited "inability to maintain proper weight, general nervousness, excessive sweating, visual defects, optic atrophy, hernias developed during periods of emaciation, cardiac and gastrointestinal complaints and bone defects." He also speculated that "malnutrition may influence the susceptibility to, or the course of, such important diseases as arteriosclerosis, hypertension, neoplasms, allergies, cirrhosis of the liver, peptic ulcer, and certain of the anemias," and thereby shorten the life span. He further suggested that "the tremendous strain and trauma of just staying alive under dire circumstances could theoretically exhaust the adrenal glands and may contribute to adrenal depletion later in life." He felt that the level of "general experience was sufficiently substandard in terms of nutrition, fatigue, stress, and lack of medical care as to result in permanent residuals."

CONTROLLED EXPERIMENTS

Although controlled laboratory experiments on stress and deprivation are hardly the equivalent of prisoner-of-war experiences, they are relevant to this discussion in that they emphasize how quickly the effects of stress and deprivation manifest themselves in the human organism.

In 1956 the Group for the Advancement of Psychiatry[2] reported on the experimental investigation of the various factors which might be involved in forceful indoctrination of prisoners: e.g., "brain washing" or "thought reform". In evaluating their findings, it must be recalled that the investigators were focusing on only one stress at a time; the subjects were volunteers and had every reason to believe that the experimenters were benevolently inclined toward them; also, a definite date for termination of the experiment was set.

Brozek, Keys, Schiele and others[2] conducted a series of experiments at the University of Minnesota on the consequences of a starvation diet: 1600 calories a day for six months. This diet included adequate minerals and proteins and was better than that offered in prisoner-of-war camps. Termination time was clearly indicated; every effort was made to maintain morale, and adequate living quarters were provided.

LOSS OF PHYSICAL FITNESS

Within the six-month period the subjects lost one fourth of their body weight and demonstrated profound changes in physical fitness as well as increased irritability, depression and pronounced apathy. Complex prolonged tests of intellectual functions were difficult to perform. The shadow of the heart diminished in size and changes occurred in the electrocardiograms. Twelve months were required for complete physical and psychological restitution.

LOSS OF SLEEP

Tyler[2] studied the effects of sleep deprivation on 350 volunteers extending up to

112 hours. Between 48 to 72 hours, difficulty in thinking and perception was noticeable; by 100 hours, psychotic phases were frequently manifested.

ISOLATION

The literature on isolation and sensory deprivation has been well reviewed by Ruff [3] Isolation produced generalized impairment of perception with deficits most striking in tests of visual-motor coordination, shape constancy, accuracy of tactful perception and spatial orientation. Most studies reported difficulties in maintaining goal-directed thought. Measures of reasoning and problem-solving showed deficits, while simple recall or rote learning tended not to be affected. Somesthetic changes and body-image disturbances were frequently reported along with some hallucinatory experiences. Efforts to measure affective changes have consistently demonstrated signs of discomfort and irritability to the point of anxiety panic attacks.

EFFECT OF STRESS

Also pertinent to this discussion is the work of Selye [4] on the general adaptation syndrome to stress. He postulates that, if stress is sufficiently severe and prolonged, it can cause certain changes in the structure and chemical composition of the body. These faulty adaptive reactions can encourage other difficulties such as high blood pressure, ulcers, rheumatic afflictions and cardiovascular and kidney diseases.

MAN'S SEARCH FOR MEANING

The experiences of severe psychological stress and physical deprivation as recounted by the survivors of the internment camps are probably more relevant to the actual prisoner-of-war experience and provide a dramatic contrast to the limited experimental laboratory situation. Although many excellent accounts exist, the graphic picture presented by Viktor Frankl [5] in Man's Search for Meaning is particularly appropriate in understanding how such experiences could result in long-term delayed residual effects of both a psychological and a physical nature.

MUSSELMAN

Survival seemed a matter of accident; the chances were one in 20. In the camps after the initial state of shock and terror, apathy became the dominant attitude, sometimes to such an extent that the prisoner became a "musselman", a term applied to a prisoner who just gave up the struggle to live and died. Regressive behavior was universal as an adaptive mechanism since phantasy served as an outlet [6] for aggressive reactions toward the DD. Denial of reality, as Bettelheim points out, made the intolerable, tolerable. Any manifestation of individuality was punishable by death; interpersonal isolation was the rule since self-survival was the goal. Frankl states: "It is a peculiarity of man that he can live only by looking to the future,' [5] and in the CC camps even this was denied.

CONCENTRATION CAMP SYNDROME

The majority of survivors of the internment and prison camps displayed a syn- 11
drome which has been labelled the post-KZ syndrome or concentration-camp syndrome, characterized by weight loss, emotional and autonomic lability and instability, irritability, apathy, decreased self-esteem, depressive trends and difficulty in concentrating. The long-term effects of this experience received little notice until the late 1950s when articles began to appear and probably provided the basis for the Restitution Laws enacted by the Federal Republic of West Germany. No accurate figures are available, but Bensheim [8] reports that in 1960 half of all patients in an NP clinic in Haifa were under treatment for residues of Nazi persecution. The pathologic effects were discernible not only among survivors of the camp but in persons who were in hiding or on the run.

The Concentration Camp syndrome has been described as marked anxiety with irritability, restlessness, apprehensiveness, and a startle reaction to ordinary stimuli. Somatic involvement of almost all organ systems has been reported. Obsessive ruminative states have been noted; most victims seem to feel that nothing of real significance has happened in their lives since these experiences. Their symptoms are very

similar to those described after prolonged combat stress or by the survivors of Hiroshima. Depressive features of the Concentration-Camp syndrome seem associated not only with mourning for departed relatives & friends but also with survival guilt, which Chofoff (9) feels may be associated with the illusion that thereby murdered relatives are kept alive, or may be related to death wishes against others in this personal battle for survival.

JAPANESE vs. GERMAN PRISON CAMPS

In 1954 the U.S. Government published an evaluation (10) of the experiences of prisoners of war in Japanese & German prison camps. Two groups of prisoners of approximately 2,000 each were compared with groups of veterans who had been exposed to combat only. Japanese prisoners of war averaged 38 months in prison camp with 34% dying before liberation. The European group averaged ten months in camp with only 1% dying before liberation. During the first two years after liberation the Japanese ex-prisoners of war showed a marked mortality rate and then a diminished but still excessive rate during the next four years. They also showed a wide variety of illnesses which interfered with their ability to work. The European prisoners of war showed no statistically significant differences from their combat controls in mortality rate, physical disability or inability to work. Six years later, however, the European veterans showed a relative increase in malnutrition, psychoneurosis, and gastro-intestinal disorders.

DANISH, FRENCH, GERMAN, AND NORWEGIAN STUDIES

Danish researchers (12), evaluating 1,300 surviving Danish prisoners of war, found that 75% of the ex-prisoners reported complaints similar to the KZ syndrome six years after the war. The authors found a correlation in severity of symptoms with degree of weight loss and duration of imprisonment. They comment that the etiology must, to a great extent, be conditioned by somatogenic and lesional factors.

The most intensive and exhaustive study of the prisoner of war has been carried out in Norway by Strom, Refsum, Eitinger and others (13) who were asked to evaluate Norwegian prisoners of war who had made a good recovery during the immediate post-war period and had managed to adapt themselves well over a period of years but were then showing symptoms of breakdown. Three hundred cases were examined, of which only the first 100 were reported.

LATE SYMPTOMS

At the time of the evaluation, 15 to 10 years after imprisonment, increased fatigue, impairment of memory, dysphoric mood, emotional instability, sleep impairment, feelings of insufficiency, loss of initiative, nervousness, restlessness, irritability, vertigo, vegetative lability and headache were noted in the majority of patients and appeared to be similar to the Concentration-Camp syndrome noted by the Danish investigators. This syndrome could not be related to pre-imprisonment adjustment but rather was correlated with duration and degree of severity of internment, loss of weight, head injuries and serious infectious diseases. Psychological tests indicated a definite organic pattern in 82 cases, and trends toward a deviant pattern were noted in 10 others.

NEUROLOGIC FINDINGS

Clinical neurological findings were positive in 88 cases; positive psychiatric symptoms typical for chronic brain syndrome were found in 85 cases. A pneumoencephalogram could be performed in 89 cases; of these, three were technical failures; in 75 cases the findings were pathological. The spinal fluid was examined in 93 cases with 29 pathological findings; of the 96 cases examined by EEG, 27 were pathological. When at least four of these independent methods demonstrated cerebral dysfunction, it was assumed that organic brain disease was more than probable. With this criterion 90% suffered from organic brain dysfunction. From autopsy reports on malnutrition victims, Osvik, one of the co-authors, found reduction of the anterior pituitary lobe and a diminution of the heart.

EMPLOYABILITY

In the social-medical examination of these ex-prisoners, all of them were classified as completely fit for work prior to internment. However, at the time of the examination, 35 were not working, 36 were critical with regard to continued employmnet, and only 29 could be said to be in temporarily satisfactory employment. Seventy-nine of the subjects appeared to have lowered work capacity before 1950 while 18 noted no reduction in capacity until after 1950. Only 3 felt that they were still fully capable of working. The Norwegian committee attributed the work disability to the KZ syndrome and recommended to the Norwegian government increased compensation for them. 13

INTELLECTUAL DECLINE

The German Federal Veterans Administration in Cologne studied the long-term results of nutritional deficiency and psychological stress in 300 prisoners of war by means of psychological tests. One fifth of this group showed a greater decline in intellectual abilities than might be expected from the normal againg process, the greatest loss appearing in those tasks which required attentiveness and ability to learn new tasks. "in general, we can recognize a disturbance in intellectual mobility and elasticity." 11

PSYCHIATRIC PROBLEMS

In France Raveau[11] reported the results of his examination of 466 French survivors of internment 10 to 15 years after their return from captivity. In 11% he noted neurological findings, of which 7% showed signs of epilepsy; 89% had psychiatric problems which he divided into 3 categories: 24% seemed to involve a "more particularly organic disorder and were characterized by premature exhaustion, residual asthenia, and premature senescence; 29% manifested neurotic conflicts related to traumatic prison experiences, and 37% showed the previous two manifestations with signs of diencephalic alterations."[11]

Studies by other participating countries, though less elaborate in design, supported the Conference conclusion that a process of premature aging, both somatic and psychic, could be well documented in former prisoners of war.

The Conference made the following recommendations: "It was their opinion that it was necessary: (1) to eliminate all legal time limits for submitting applications in connection with disability; (2) to have these persons benefit from the presumption of origin and aggravation, without time limit, which excludes any provision tending to reduce the disability rate.on the grounds of the applicant's age or because of the time when the application for pension was made." Furthermore: "The conference recommended the adoption in the various countries of a system of reparations based on these principles." 11

It is perhaps time, in line with Dr. Caplan's strongly expressed opinion, to re-evaluate the medical and vocational status of ex-prisoners of war in the United States.

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Longevity is worth having only when it is accompanied by the temperamental harmony which makes its possessor, even in extreme old age, take delight in the sheer joy of living.---Forbes Gray

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FEPOW ENTITLEMENT & SO-CALLED PSYCHONEUROSIS: & ASSESSMENTS

Desmond Fitzgerald Moore MRCS LRCP DTM & H April, 1973 (FEPOW--FAR EAST-POW)

Approximately 25 years after Release of FEPOWS, the Roehampton Report published May 1971, viz. "A FEPOW Survey" recorded of its 4,684 cases investigated, no less than 1,904 i.e. 40.6% exhibited residual neuropsychiatric sequelae. This ratio is so high as to be a reflex, of itself, of abnormality, of a condition, and due to experience as a FEPOW; and regarding its duration, to be compared with irreversible changes like "D.A.H." and "persistent headache" of trench warfare in World War I; and productive of a characteristic state, as to constitute a definite syndrome.

It is not surprising consequently to find in many of the earlier investigations carried out in special hospitals on FEPOW survivors, a number of the specialists examining them, refusing to diagnose them as ordinary psychoneurotics, but advising them as suffering from residual nervous conditions, and diseases, but defining their causes, for example, in these term: "typical neurasthenic syndrome common to ex-FEPOWS"; "the nervous symptoms so often found in the ex-FEPOW"; "suffering from FEPOW anxiety state (so-called for want of a better name) which I believe to be a direct effect of nutritional diseases as a FEPOW"; "his mentality is typical of all returned ex-FEPOWS from the Far East and in my opinion his undernourished appearance is partly psychological or partly physical"; "that psychological reactions were as much of organic change in frontal and sensory pathways of the brain as others".

And in a case with visible residual organic nutritional central neuritis, the neurologist added: "I do not think the slight degree of organic dementia attributable to prolonged nutritional deficiency, can be disconnected."

Those who are familiar with long-standing pellagra are well aware of irreversibility of some symptoms, as indeed too, in those nutritional diseases with organic nutritional neurological involvement, of nutritional retrobulbar neuritis, nutritional ataxic syndrome, or spastic encephalopathies of beri-beri, or pellagra. And all these tropical nutritional conditions, exact causes of which are still not known, all affects the nervous sensory system.

It is also not without relevance to interpretation of what might appear to be due to functional symptoms only, that in the Roehampton follow-up no less than 679 of the 4,684 cases of FEPOWS investigated were found to have some form of organic neurological disease. That is 6.3%. And that it is certain that there were many others, is borne out by experience of these conditions; and indeed even strikingly confirmed in FEPOWS. Thus in 1947, Crawford and Reid carried out a postmortem on a FEPOW who had diedfrom the external cause, and who had no special complaints or shoed visible signs of neurological defects, yet the PM showed the typical spinal cord changes to those as originally described by Deeks and Scott in their classical Post-mortem reports on nutritional central neuritis. So, Crawford and Reid expressly warned of the danger

of ascribing residual nervous symptoms to psychogenic causes alone, as of course, also the difficulties of absolute diagnoses in life.

It is again extremely important (as any tropical nutritional clinician would endorse) to remember that all these nutritional conditions in their active stage, do show characteristic mental accompaniments.

[In my Lancet article January 1937 on nutritional retrobulbar neuritis, there is contained a photograph of one "Joe", with gross ariboflavinosis, also severe retrobulbar neuritis, and nutritional ataxic syndrome, and which demonstrates very well accompanying severe disturbed mental state.]

And to quote from Jolliffe's "Clinical Nutrition": "Starvation, the starving man complains of weakness, easy fatiguability, dizziness on sudden movement, loss of sexual power, polyurea dyspepsia, depression, apathy; a feeling of growing old."

Beriberi. Beri-beri is a clinical syndrome, characterised by neuropsychiatric, circulatory, gastro-intestinal, and metabolic changes.... anorexia, fatigue, apathy, digestive disturbances, disturbances of sleep, heart consciousness, parasthesias, inability to concentrate.

Pellagra (and to this is conjoined ariboflavinosis which frequently is coexistent). Insomnia, loss of appetite and strength, indigestion, diarrhoea, abdominal pain, burning sensations in various parts of the body, vertigo, headache, nervousness, apprehensiveness, disstractibility with flights of ideas, mental confusion, forgetfulness.

Much, of course, depends on the duration of illness, and so forth.

To these, in FEPOWS, has to be added the many and often repetitive grossly severe tropical and other diseases; and especially malaria, and the dysenteries (so well described by Coates, Australian Medical Journal 1/6/46).

And here, again, to those familiar with or who study reports of conditions in other lands, or themselves have seen results of conscripted labour, of bad institutional management, of periodic famine conditions due to bad economics, climatic conditions with failure of crops, it is well known how diseases, ordinarily endemic to an area, may rise to hyper-epidemic proportions and satastrophic results, under such conditions, and of which FEPOWS presented so often an example. There certainly could remain for those who survived - permanent traumatic effects.

To all these, to be added in FEPOWS, both physical and mental stresses as well as of illness itself, of captivity conditions generally, the brutality and beatings and so forth by the Japanese.

It will again be appreciated from reports mainly from Dutch, Danish, and Norwegian studies and follow-up of Concentration victims in German camps, all these authors recognise a definite mental aftermath. They do not call this Psychoneurosis, but the KZ syndrome, a clear-cut entity. Moreover, they not only point out the permanency of the condition, but in a distinct proportion the symptoms to have become more marked; and , in some, evidence of organic changes.

I believe that one of the most important requirements of the recently reconstituted "Special FEPOW Unit" with its newly accredited powers now granted by DHSS, will be to examine, and in retrospect, the whole of these entitlements to reorientate the apparently greatly varying diagnoses into a properly constituted whole; just as one hopes, too, that many of these cases will be re-submitted to those Boarding Regions, where the tystem of attachment to them of tropical disease consultants has also been revived, and with it, too, it is hoped, greater freedom to assess as actual Chairmen or as Advisors to Chairmen of Boards.

I have been continuously opposed to advising neurosis in a FEPOW as a separate condition, not simply because as a tropical physician I believe that they are partly organic in origin, but also because I do not accept it as compatible with even normal thinking to insist that nearly half of those who served, and became FEPOWS, were "neurotics", whereas they were, in fact, prior to being made FEPOWS, of the most stable of their generation.

Of course there were exceptions. There always will be, but exceptions should never become a Rule.

Every war produces its own fanfare of propaganda, nothing is too much for the returning soldier. None are to be sooner forgotten by those who have not served. The term "psychoneurosis" by itself is no different from that of the constitutional neurotic. And to label a FEPOW as such, however unwittingly, is not only, with few exceptions, quite wrong, but can do positive harm, for who will employ a constitutional neurotic? And yet employment is part of rehabilitation and hope of recovery.

So I have always advised residual nervous symptoms should be conjoined with the major cause, Malnutrition and Privation, which indeed they are part of. And it gives the FEPOW a better chance, for with that prefix, ironically perhaps, he wil get the sympathy which otherwise might well have prevented employment.

And once more, it is to be seen Roehampton does not label FEPOW survivors as psychoneurotics, but advise their condition as a direct sequel to captivity.

2. ASSESSMENTS

Basically I believe they are much too low. In many, indeed probably a majority of, FEPOWS, their experiences have profoundly affected their life. And it appears to me this is particularly true of those with residual associated nervous symptoms. Also there is an essential difference between the disablement of the constitutional neurotic from a FEPOW.

The constitutional neurotic generally manages to adjust himself from an early age and throughout life to his disability. He refuses responsibility he knows he cannot undertake. Not so for FEPOWS. For them no choice, and for those who were not members of the Regular Services, and who survived as FEPOWS, forced to try to resume work, many were no longer able to do so, or, if so, under conditions of change for them, so completely different and so much altered.

And how can minor assessments be possibly considered as adequate with signs persisting all these years? And residual nervous effects, yet symptoms form the greatest single disablement of any in surviving FEPOWS. Is not the Canadian grant of an over-all 50% pension for its FEPOWS, after all a fair and resonable one?

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"LIFE STYLE SHOCK "
THE PSYCHOLOGICAL EXPERIENCE OF BEING AN
AMERICAN PRISONER OF WAR IN THE VIETNAM CONFLICT

The following is an attempt to describe the profound psychological impact of being a POW. It is based on information and input from a number of sources: studies of POW's from WW II and Korea; Department of Defense interviews with Vietnam Era servicemen who escaped or were released; and the reasoned analyses of those knowledgeable in this area. It also reflects the subjective views of the author who was himself a POW during WW II. Its purpose is to increase the understanding and sensitivity of anyone who may become involved in the lives of returned POW's. While it should be considered a generally accurate portrayal of the realities and impact of life in a captive environment, it must be remembered that each POW is a unique individual whose experiences in captivity were unique to him alone.

PERSPECTIVE

The manner in which each human being lives and works and plays and plans for tomorrow is of central importance to his existence. Through this life style he seeks to find meaning, direction and fulfillment in life. Through it he seeks to function with reasonable confidence in his ability to cope with change, adversity and threats to his survival and with reasonable confidence that he counts with -- and can count on -- the support of his family, associates and his society.

What happens when that life style is suddenly and completely altered? What happens when all of the things that sustained and gave direction to life are missing? What happens when the occurs because environmental forces, physical and social, no longer can be relied on to be supportive, but instead are seen as unfamiliar, unpredictable and hostile? This is the life style shock of becoming a POW. It is also the life style shock of later re-entering a world that psychologically had ceased to exist. It is made more complex by the fact that life style shock also occurred for close family members of those who were captured - and it occurs again when the repatriated POW comes home. It occurs in a very different way for families of the man who was missing in action for many years with the possibility that he might come back and now must adjust to the reality that he will not.

"INITIAL IMPACT OF BECOMING A POW"

> "Almost from the moment of capture you have two devastating feelings. One, that it's the end of the world, that you have lost and will never again be a part of that world to which you really felt you belonged and counted for counted for something. Second, an intense fear of death that never leaves you. You see your capturers as totally omnipotent and yourself as totally helpless. You know that any threat from him is a promise that could happen right now and you dare not challenge anything. Your confidence goes downhill radically almost immediately." A Vietnam POW's.

It is almost impossible to overstate the enormity of the meaning of captivity to the POW. This impact is heightened and deepened by his immediate isolation from other Americans and the desperately needed mutual reassurance this could bring. Self-esteem drops. He was somebody, now he is nothing. With it drops his confidence to cope actively with his environment. His fear of death is not panic but dread based on the realities of the situation that he is valued not as a worthwhile human being but only a symbol of the "enemy". He feels that this "value" is tentative at best and may end at any moment, and his life along with it. While he clings to the vague hope that he may survive this situation, it does not sustain him since he continually experiences the realities that prevail all around him. He perceives himself as under the complete control of forces which are unconcerned about his survival, indifferent to his immediate needs, aggressive and punitive, and totally unpredictable. As a result, he sees himself as highly vulnerable, dependent, helpless, and lacking both in self-esteens and a sense of identity relevant to him in this alien world. He perceives other POW's as powerless, without status or influence, unsupportive, distant, and not really concerned about him. The shock of captivity dulls his sensitivity to stimuli and leaves him with an oppressive feeling of depression and resignation.

It is important to recognize that the complete loss of an active, self-responsible life style that served to continually reaffirm self-worth, and its replacement by a passive compliant one that does not reinforce self-esteem, is the crux of the psychological change, not simply the fear of death, torture or punishment.

"THE PROCESS OF ADAPTATION TO THE CAPTIVE ENVIRONMENT"

> "When you are captured you have two choices, to survive or not survive. You have a total change in values; you relate everything to your chance of survival. You try to minimize harassment from guards by not challenging them; try to maintain the delicate balance of health and security. You don't dare think about home, it becomes too depressing afterwards; you become tremendous time-killers or have fantasies, talk to yourself, play games in which you become somebody who always succeeds and never fails. You gear down, slow everything down, and don't let yourself feel things very much." A Vietname POW's.

The solution to the problem of surviving psychologically as well as physically under conditions that deny opportunities for life styles other than passive compliance is a complex one. Resignation to the physical environment of captivity, choosing the adaptive response of following the rules all the time, compliance with and accepting the numerous routines of prison life maximize the likelihood of continued physical survival. An attitude exists of expecting to be disappointed in almost all things involving the capturers, with a readiness to accept this. It avoids feelings of frustrati n and the danger of triggering other intense but "inactive" feelings.

"Gearing down" is the most popular way of describing the adaptive process. Attention that cannot be directed toward important activities is "redistributed". Simple acts as folding a towel or blanket are spread out into long periods of time to absorb attention in something "neutral". Doing it right also provides an important way of experiencing at least some degree of adequacy and success in something. This focusing on the immediate and the routine serves a protective function in that it enables the person to shut out more emotionally laden feelings, thoughts and hopes. A near total insultation from important feelings and wants prevails. The process causes the prisoner to become much less aware of and concerned about the passage of time. The focusing on the immediate environment and present moment enables the POW to avoid thinking about towmorrow and the world that means so much, but is so totally inaccessible.

Time is filled, emotions are avoided, troubles are minimized, but what happens to self-esteem, to self-confidence? The repetitive acts of compliance to the routines of prison life and the lack of opportunity to perform meaningful activities gradually erode the POW's capacity to really see himself in active, self-responsible roles that made up his pre-capture life style. Self-esteem is maintained to some degree by gratuitous, superficial, purposeful fantasies of seeing one's self in great roles in which adequacy, respect, status and success in coping with every challenge are simultaneously experienced. Social relations (basic human contacts with someone who shares one's interests, views, etc.) are similarly fabricated by those forced to live in isolation from other POW's.

It is important to recognize that the POW has learned very well how to adapt to and endure a depriving, dehumanizing, and threatening environment. These adaptive mechanisms are consciously engaged in and serve to preserve sanity. They are not symptoms of a breakdown of an effective reality orientation and behavioral response pattern. In fact, learning how to endure the stress of imprisonment, to survive, can have constructive as well as destructive psychological consequences. The POW is changed by his experiences as he necessarily must be. Personal growth, i.e., attitudes based on primary hunam values and the ability to tolerate frustation and disappointment, is possible and does occur. But the damage has been done to an integrated, chesive life style for adaping in the environment and reintegrating with adaptive patterns common in his own society.

"THE PROCESS OF ADAPTATION TO FREEDOM"

> "Freedom is frightening and unreal. The freedom to choose simple alternatives can be a tremendous burden to carry. Adjustment is tough, you feel like a foreigner in your own world. You want to trust but are ready to retreat since you've learned to expect disappointment. However, if a "friendly" system lets him down, is oppressive, or keeps him in a state of uncertainity, it is more devastating to him and makes him cynical of any environment or anyone else. You have to sort out your own life. You soon sense how far away you have been from a world you once took for granted." Vietnam POW's.

It is critical to recognize the devastating change in self-concept that has occured and the conditions under which a positive self-image and life style can be restored. The POW must be allowed a moment in time to reintegrate himself, to shed the extreme psychological defenses against inner feeling and outer stress that were necessary for survival in the emotional saualor of the captive environment, to re-establish his identity. Just as he felt immediately after capture he

again finds himself in a world in which he has no assured status as a peron with a defined life style involving active relationships to those around him. He recognizes that his relationship is historical and sentimental rather than relevant and current. And he is fearful that the image he presents will not be reacted to favorably. He must also have a moment in time to become aware of the events and changes that have transpired in his absence. There is a staggering gap in their experiences concerning what has happened in their homes, work, and society.

The capacity of the returned POW to deal with new stimuli is at first severely diminished. He had to "gear Down" to survive, now he must "gear up" to assimilate and cope with the very high level of input of stimuli occurring in our modern society. Fairly extensive adjustment of values occurs within the individual during a long period of imprisonment. He will have new views of old situations and we must expect a collision between the different set of values.

"IMPLICATIONS"

To be an inherently helpful person to the returned POW and his family, an empathic understanding of how this man has been living is crucial. Returned POW's are very much concerned that no one will understand what it was like. Communication is also crucial in the need for accurate feedback. After years of living with uncertainty they need straight forward answers, good or bad. Where sincerity or credibility are in doubt, the opportunity to be of help to the POW is greatly reduced. Interpersonal interactions must be not only empathic and honest they must also be open and informative rather than authoritarian and directive. The returned POW needs time, room, and options in which to maneuver so that he can play an increasingly active role in the process of re-establishing himself as a valued and worthwhile person to his family, his environment, and himself.

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Coordinator
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Washington, D.C.
December 1, 1972

Dear Fellow-Ex-Prisoners of War,

In the past many of you have perhaps thought that you were one of few who suffer from a nervous condition, this is far from true. In fact, after reading this packet you realize that many, if not all of us, suffer some degress of nervousness. Research statistics establish this.

Many ex-pow's will not go to a psychologist or psychiatrist and some are even insulted if they are told to by their doctor. Nervousness is a symptom of possible illness just as aching joints may be a symptom of rheumatism.

Nervousness can be the after-effect of extreme stress (both physical and psychological), avitaminosis and, or malnutrition. Remember comming home after, months or years of brutal captivity and the adjustment to freedom and re-entering society. This joyous occasion was also a stressful one to us.

You know it is fashionable today to have your own "shrink" and who has a better right to one?

THE FOLLOWING WAS TAKEN FROM THE CANADIAN PENSION COMMISSION MEDICAL GUIDELINES, MAY 7. 1976 WHICH WAS AUTHORED BY DR. H.J. RICHARDSON, FORMER CHIEF MEDICAL ADVISOR OF THE COMMISSION. (EX-PRISONERS OF WAR) HONG KONG.

AVITAMINOSIS WITH RESIDUAL EFFECTS:

THIS TERM HAS BEEN USED BY THE CANADIAN PENSION COMMISSION TO IDENTIFY THE SYMPTOM-COMPLEX AS PREFERABLE TO OTHER SYNONYMS SUCH AS BERIBERI, PELLAGRA, MALNUTRITION-DEPRIVATION SYNDROME, ETC..

RESIDUAL DISABILITIES RECOGNIZED BY THE COMMISION AS RELATED TO AVITAMINOSIS & DIETARY INFUFFICIENCY:

NEUROLOGICAL - (SUBJECTIVE & OBJECTIVE) - DISTRESSING PARESTHESIA, WEAKNESS & ATROPHY OF MUSCULAR TISSUE DURING CAPTIVITY WERE FOLLOWED BY A PARESTHESIA OF FEET & LEGS DESCRIBED AS "HOT FEET". THERE WAS IMPAIRMENT OF SENSATION OF COLD; WITH SOME CASES OF FROST-BITE RESULTING, REQUIRING A NUMBER OF SYMPATHECTOMIES. IT WAS COMMON PRACTICE TO LEAVE THE FEET UNCOVERED AT NIGHT. THIS TYPE OF SYMPTOM, COMMONLY MENTIONED AT FIRST, IS PERHAPS LESS SEVERE NOW, BUT MANY PENSIONERSSTILL HAVE THE SYMPTOMS. THE SYMPTOMS ARE AT LEAST AS DISTRESSING AS THOSE OF FOOT STRAIN, ARE NOT RELIEVED BY MEDICATION OR ARCH SUPPORTS AND DISTURB SLEEP. USUAL ASSESSMENT RANGE, 5% to 10%. IMPAIRMENT OF SENSATION & FACILITY IN THE USE OF THE HANDS HAS BEEN DOCUMENTED BY DR. E.V. KRAL & ASSOCIATES OF MONTREAL. OTHER FINDINGS, DISTURBED BALANCE & ATAXIA ARE TAKEN INTO ACCOUNT WHEN THE ASSESSMENT IS BEING ESTABLISHED. BOTH OF THESE SYMPTOMS VALIDATE THE CONCEPT OF WIDESPREAD NEUROLOGICAL DAMAGE.

PSYCHIATRIC - MOST, IF NOT ALL, MEN RETURNING FROM JAPANESE CAPTIVITY TOOK LONGER TO RE-ADJUST TO CIVILIAN LIFE THAN OTHER VETERANS. THIS HAS BEEN SHOWN BY MORE THAN USUAL DIFFICULTIES IN SOCIAL AND ECONOMIC ADJUSTMENTS.

IMPAIRED TOLERANCE TO THE STRAINS OF DAILY LIFE ASSOCIATED WITH ANXIETY, TENSION AND DEPRESSION ARE MUCH COMMONER & MORE SEVERE IN THESE VETERANS THAN IN ANY OTHER LARGE POPULATION OF VETERANS. CORROBORATION OF THIS POINT OF VIEW COMES FROM A STUDY OF AMERICAN & AUSTRALIAN PRISONERS-OF-WAR BOTH IN JAPAN AND KOREA.

THE NEUROPSYCHIATRIC DISABILITY IS ASSESSED WITHOUT RULING IN MOST CASES UNDER THE DIAGNOSIS OF AVITAMINOSIS WITH RESIDUAL EFFECTS, PARTICULARLY WHERE THE DIAGNOSIS IS IN DOUBT, ASSESSMENT IS MADE IN ACCORDANCE WITH THE TABLE OF DISABILITIES FOR NEUROPSYCHIATRIC CONDITIONS.

POST-DISCHARGE RULINGS:

POST DISCHARGE CONDITIONS MAY BE CLAIMED AS CONSEQUENTIAL TO AVITAMINOSIS WITH RESIDUAL EFFECTS..... THE DEGREE OF RELATIONSHIP OF A CONDITION CLAIMED AS CONSEQUENTIAL UPON AVITAMINOSIS WITH RESIDUAL EFFECTS VARIES INVERSELY WITH THE TIME INTERVAL BETWEEN CAPTIVITY & THE ONSET OF SYMPTOMS OR SIGNS DIAGNOSTIC OF THE DISEASE...

SPECIFIC AREA OF CONSEQUENTIAL RULINGS:

NERVOUS CONDITIONS - PSYCHOTIC ILLNESS IS THE ONLY AREA OF NERVOUS DISEASE THAT REQUIRES A RULING, AND THIS IS NECESSARY ONLY WHEN UNDOUBTED PSYCHOTIC ILLNESS IS PRESENT. ALL OTHER NERVOUS CONDITIONS ARE ASSESSED WITHOUT RULING UNDER THE PSYCHIATRIC COMPONENT OF AVITAMINOSIS WITH RESIDUAL EFFECTS.

AS WITH ALL PENSIONERS, A P.O.W. OF THE JAPANESE MAY CLAIM FOR ANY OTHER CONDITION ON A CONSEQUENTIAL BASIS WHICH HE CONSIDERS IS RELATED TO THE AVITAMINOSIS WITH RESIDUAL EFFECTS. SUCH CLAIMS WILL BE CONSIDERED ON THEIR INDIVIDUAL MERITS.

TRAUMATIC NEUROSES: WE ARE ENCLUDING THE FOLLOWING INFORMATION ON TRAUMATIC NEUROSES, AS MANY OF US, AS FIGHTING MEN IN WAR TIME AND AS PRISONERS OF WAR, CERTAINLY HAD MANY TRAUMATIC EXPERIENCES. THESE EXPERIENCES COULD LEAD TO TRAUMATIC NEUROSES NOW, MANY YEARS LATER. THIS DISTURBANCE IS FREQUENTLY OVERLOOKED IN MEDICAL EXAMINATION.

"TRAUMATIC NEUROSES IN VIETNAM RETURENEES: A FORGOTTEN DIAGNOSIS?"

AUTHORED BY DRS. THEODORE VAN PUTTEN & WARDEN H. EMORY, NOVEMBER 1973, AFFILIATED WITH THE VA HOSPITAL, BRENTWOOD CALIFORNIA, SHOULD BE SIGNIFICANTLY HELPFUL IN THE PREPARATION & PROSECUTION OF CLAIMS FOR SERVICE-CONNECTION FOR NEURO-PSYCHIATRIC DISABILITIES SUFFERED BY VIETNAM-EAR VETERANS.

IT IS IMPORTANT TO NOTE THAT "...COMMONLY, THE ONSET OF THIS DISTURBANCE IS NOT APPARENT TO THE VETERAN OR TO OTHERS UNTIL 15 - 30 MONTHS AFTER DISCHARGE. THE PRESENT STUDY IS TO DRAW ATTENTION TO THE FACT THAT THE DIAGNOSIS OF TRAUMATIC NEUROSIS IS FREQUENTLY OVERLOOKED IN VIETNAM RETURNEES..."

WITH REGARD TO WORLD WAR II & KOREAN CONFLICT VETERANS'CLAIMS FOR INCREASE FOR COMBAT NEUROSIS, IT WOULD BE DESIRABLE TO CITE "...APPROPRIATE TREATMENT OF COMBAT NEUROSES IS CRUCIAL,SINCE FOLLOW-UP STUDIES DOCUMENT THAT SYMPTOMS MAY NOT PASS WITH TIME. ARCHIBALD ET AL. [21,22] IN A 15 & 20 YEAR FOLLOW-UP OF COMBAT NEUROSIS SHOWED THAT SYMPTOMS MAY BECOME AGGRAVATED WITH AGING. LEOPOLD & DILLON REPORTED ON THE IMMEDIATE EFFECTS OF A CIVILIAN MARITIME EXPLOSION & ON THE STATUS SOME 3½ TO 4½ YEARS LATER. THEY FOUND APPRECIABLE DETERIORATION IN 71% OF CASES, & CONCLUDED THAT TRAUMATIC NEUROSES WORSEN WITH TIME..."

TRAMATIC NEUROSES OF WAR ARE A PRIVATE DISEASE AS WELL AS A PUBLIC CONCERN. THE INCIDENCE OF NEUROPSYCHIATRIC ILLNESS IN SOLDIERS SERVING IN VIETNAM HAS BEEN FOUND TO BE SIGNIFICANTLY LOWER THAN IN RECORDED PREVIOUS CONFLICTS. CONSEQUENTLY, VIETNAM RETURNEES HAVE RECEIVED LITTLE PSYCHIATRIC ATTENTION. GOLDSMITH ET AL. [4] REPORTED ON TEN VETERANSWHO DEVELOPED PSYCHIATRIC PROBLEMS AFTER RETURNING TO THE U.S.. HE ATTRIBUTES THEIR PSYCHIATRIC ADMISSIONS TO LONG STANDING CHARACTEROLOGICAL DIFFICULTIES & TO UNRESOLVED FAMILY & MARITAL PROBLEMS. IN NONE OF THESE 10 PATIENTS IS THE DIAGNOSIS OF TRAUMATIC NEUROSIS MADE, ALTHOUGH SEVERAL HAD COMBAT NIGHTMARES, IRRITABILITY & STARTLE PATTERNS, & A GENERAL CONTRACTION OF EGO FUNCTIONING. STRANGE & BROWN ALSO MAKE NO REFERENCE TO TRAUMATIC NEUROSES IN THEIR STUDY OF 60 INPATIENT VIETNAM RETURNEES. A 367 PAGE PUBLICATION ON THE EMOTIONAL ADJUSTMENT OF THE VIETNAM VETERAN MAKES ONLY PASSING MENTION OF COMBAT NEUROSIS. SOLOMON ET AL. REPORT ONE CASE OF WAR NEUROSIS WHICH HAD MASQUERADED AS INTRACTABLE SURGICAL PAIN FOR TWO YEARS. SHATAN (1973) AND LIFTON (1972) [9] NOTICED "DELAYED EMOTIONAL & BEHAVIORAL REACTIONS TO COMBAT" WHICH ESCAPED OFFICIAL RECOGNITION BECAUSE THE VETERAN BELIEVES THAT THE ESTABLISHMENT HAS "LITTLE AUTHENTIC COMPASSION". THEY DESCRIBED SEVERE GUILT, PROCLIVITY TO EXPLOSIVE AGGRESSIVE REACTION, "PSYCHIC NUMBING", & SEVERE ALIENATION FROM FEELINGS & HUMAN BEINGS. COMMONLY, THE ONSET OF THIS DISTURBANCE IS NOT APPARENT TO THE VETERAN OR TO OTHERS UNTIL 15 - 30 MONTHS AFTER DISCHARGE. THE PRESENT STUDY IS TO DRAW ATTENTION TO THE FACT THAT THE DIAGNOSIS OF TRAUMATIC NEUROSIS IS FREQUENTLY OVERLOOKED IN VIETNAM RETURNEES.

TRAUMATIC NEUROSES OF WAR ARE CHARACTERIZED BY CATASTROPHIC DREAMS, IRRITABILITY & STARTLE PATTERNS, A PROCLIVITY TO EXPLOSIVE AGGRESSIVE REACTION PATTERNS, & A CONTRACTION OF THE GENERAL LEVEL OF FUNCTIONING. THIS CONTRACTION OF EGO FUNCTIONING MAY RESEMBLE SCHIZOPHRENIC DETERIORATION. PHOBIC ELABORATION ABOUT THE WORLD AS AN UNBEARABLY HOSTILE PLACE IS COMMON & MAY RESEMBLE A PERSECUTORY DELUSION. AUTONOMIC INSTABILITY & PSYCHOPHYSIOLOGIC DISORDERS ARE FREQUENT [11].

EARLY RECOGNITION & APPROPRIATE TREATMENT ARE CRUCIAL, SINCE WITH THE PASSAGE OF TIME, THESE NEUROSES BECOME CONSOLIDATED & THE PROGNOSIS BECOMES PROGRESSIVELY POORER [11]. RECOGNITION OF THE SYNDROME IS ESSENTIAL SINCE THE THERAPY OF WAR NEUROSIS IS DIFFERENT FROM THE TREATMENT OF A CHARACTER DISORDER OR PSYCHOSIS. THE HALLMARK OF THERAPY IN THE WAR-NEUROSIS IS THE DE-SENSITIZATION OF THE PATIENT TO THE TRAUMATIC MEMORIES OF WAR. THE VETERAN MUST RECAPITULATE HIS TRAUMATIC EXPERIENCES IN CONSCIOUS VERBALIZATION; ONLY IN THIS WAY CAN THE EGO GAIN COMPLETE MASTERY OF THE PAST. SINCE THE VICTIM OF A TRAUMATIC NEUROSIS HAS A PRONOUNCED RELUCTANCE TO RECALL HIS TRAUMATIC EXPERIENCES, THIS IS NOT LIKELY TO HAPPEN SPONTANEOUSLY DURING NON-SPECIFIC TREATMENT.

EVER SINCE ALERTING OUR ADMISSIONS STAFF, DIAGNOSED CASES OF TRAUMATIC NEUROSIS ARE APPEARING ALMOST WEEKLY. VIETNAM RETURNEES, BECAUSE THEY REJECT AUTHORITY AND MISTRUST INSTITUTIONS, COME TO THE VA ONLY OUT OF DESPERATION. MOST HAVE LEFT VIETNAM YEARS AGO, AND MANY HAVE HAD INEFFECTIVE TRIALS OF PSYCHOTHERAPY AT LOCAL MENTAL HYGIENCE CLINICS OR WITH PRIVATE THERAPISTS. THE CURRENT EMPHASIS ON THE "HERE AND NOW" IN PSYCHOTHERAPY, IN CONJUNCTION WITH THE COMBAT VETERAN'S RELUCTANCE TO DISCUSS HIS TRAUMATIC EXPERIENCES AND THE THERAPIST'S WISH TO BE DONE WITH THE WAR, MAY EASILY CREATE A TACIT AGREEMENT BETWEEN THERAPIST AND VETERAN TO AVOID THE SUBJECT, ALTHOUGH DESENSITIZATION THROUGH ABREACTION MAY BE MORE HELPFUL. IT WOULD APPEAR THAT MUCH HAS BEEN LEARNED ABOUT TRAUMATIC NEUROSIS IN WORLD WARS I AND II HAS BEEN FORGOTTEN & NEEDS TO BE RELEARNED.

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The following are excerpts from an excellent article on the Psychological Effects of Incarceration by Julius Segal, Edna J. Hunter & Zelda Segal 1975. Center for POW Studies, Naval Health Research Center, San Diego, CA.

"UNIVERSAL CONSEQUENCES OF CAPTIVITY: STRESS REACTIONS AMONG DIVERGENT POPULATIONS OF PRISONERS OF WAR AND THEIR FAMILIES"

THE EMOTIONAL TRAUMA OF CAPTIVITY IS LIKELY TO LEAVE A RESIDUE OF PSYCHIC SCAR TISSUE THAT NEVER ALTOGETHER HEALS. THE EVIDENCE SPRINGS FROM A VARIETY OF STUDIES & CLINICAL OBSERVATIONS. A HOST OF EVALUATIONS OF RETURNED PRISONERS FROM VARIOUS NATIONS DESCRIBE BOTH ACUTE & CHRONIC CHANGES IN PERSONALITY & ORIENTATION WHICH REFLECT THE ENORMOUS STRESS TO WHICH THE POW HAS BEEN SUBJECTED.

IN A RECENTLY PUBLISHED REPORT, BEEBE POINTS OUT THAT THE MOST REMARKABLE & LONG LASTING EARMARKS OF THE CAPTIVITY EXPERIENCE IN THE ORIENT IN THE SECOND WORLD WAR & THE KOREAN WAS WERE THE PSYCHIATRIC SYMPTOMS WHICH STALKED SURVIVORS OVER TIME. THESE ARE SEEN ESPECIALLY IN THE INFLATED RATES OF HOSPITAL ADMISSIONS FOR BOTH PSYCHONEUROTIC & PSYCHOTIC BREAKDOWNS. BEEBE CONCLUDES THAT MANY OF THESE RETURNED WITH PERMANENT PSYCHOLOGIC IMPAIRMENT.

A RARE, CONTROLLED STUDY BY KRAL, PAZDER & WIGDOR OF THE EFFECTS OF PRISONER OF WAR EXPERIENCES AFTER 20 YEARS IN A GROUP OF CANADIAN POWs REVEALS A HIGH INCIDENCE OF NERVOUS TENSION, ANXIETY (BOTH FREE-FLOATING & SITUATIONAL), DEPRESSION, IRRITABILITY, SOCIAL ISOLATION, POOR MEMBORY & SLOW THINKING. SIMILARLY, AMONG NEW ZEALAND POWs, MANY REPATRIATES FROM EUROPE DESCRIBED RESTLESSNESS & INABILITY TO SETTLE, IMPAIRED POWERES OF CONCENTRATION & MEMORY, A TENDENCY TO BE EASILY AFFECTED EMOTIONALLY (NOTABLY BY A PATHETIC FILM OR MUSIC), A FEELING OF AWKWARDNESS IN MEETING STRANGERS, A STRONG DISLIKE OF CROWDS AND QUEUES, & AN OVERPOWERING DESIRE TO BE QUIET & ALONE. MANY MEN WERE INCLINED TO RESENT & OPPOSE RESTRICTIONS ON THEIR FREEDOM OF ACTION. SIMILARLY, REPATRIATES FROM THE FAR EAST DESCRIBED THEMSELVES AS NERVOUS & EMOTIONAL OR "WROUGHT UP": LETHARGIC, UNABLE TO CONCENTRATE, & CONTENT TO JUST SIT & DREAM; DEPRESSED; UNABLE TO SLEEP; EASILY IRRITATED; MENTALLY TIRED. WHILE THEY MENTIONED THAT THESE SYMPTOMS HAD BECOME LESS SEVERE WITH THE PASSAGE OF TIME, IT WAS CLEAR THAT THOSE MEN WHO HAD SPENT 3 YEARS OR MORE AS PRISONERS IN THE FAR EAST PRESENTED THE CHARACTERISTIC RESIDUALS OF CAPTIVITY.

AMONG PSYCHOSOMATIC COMPLAINTS NOTED AMONG FIRST WORLD WAR FRENCH CAPTIVES ARE DYSPEPTIC SYNDROMES OF AN ULCERATIVE TYPE, CARDIOVASCULAR SYNDROMES, INCLUDING TACHYCARDIA,DYSPNEA, TREMORS, AND 'SEXUAL DEFICIENCY'.

THE TRAUMATIC SYNDROME

Hector Warnes, M.D., Canad. Psychiat. Ass. J. Vol. 17 (1972)

THE STUDY OF INDIVIDUALS WHO ENDURED ACUTE OR PROLONGED THREAT TO SURVIVAL—DUE TO CATASTROPHES, NARROW ESCAPES, DEADLY ENVIRONMENT, CONSTANT HUMILIATIONS AND TERRORS—HAS BEEN BROUGHT UNDER SCIENTIFIC SCRUTINY FOR SEVERAL DECADES.....THE COMMON DENOMINATORS OF SUCH EXPERIENCES ARE:

RISK OF ATTACK OR INJURY
DANGER OF DEATH & A SENSE OF VULNERABILITY
FAMILY SEPARATION & LOSS
DEPRIVATION, FATIGUE, HUNGER, EXPOSURE TO THE ELEMENTS, TORTURE, ECONOMIC & SOCIAL CHAOS, AND SO ON.

IT IS WIDELY MAINTAINED THAT ALL MAMMALS HAVE INNATE INHIBITIONS AGAINST KILLING MEMBERS OF THEIR OWN SPECIES, BUT THERE ARE TWO EXCEPTIONS—THE RAT AND MAN (26). THE PROBLEM OF HUMAN AGGRESSION IS RAISED BY GENOCIDE, DIRECTED TOWARDS ONE PARTICULAR RACE OR ONE PARTICULAR RELIGION—ARMENIANS, CHINESE, JEWS AND ANCIENT CHRISTIANS (9). THE EXPERIENCE OF CONCENTRATION CAMP VICTIMS IS HERE SINGLED OUT AS THE PROTOTYPE OF THE TRAUMATIC SYNDROME, HAVING A CLINICAL IDENTITY OF ITS OWN WHICH IS PARTICULARLY OBSERVABLE IN ITS CONTENT AND EVOLUTION.....

THE PSYCHOPATHOLOGICAL REACTIONS ENCOUNTERED IN CONCENTRATION CAMP VICTIMS ARE: HYSTERICAL REACTIONS, PSYCHOPATHIC LITIGIOUS STATES, COMPENSATION NEUROSES AND QUALITATIVE CHANGES OF PERSONALITY TRAITS (41). PEOPLE SUFFERING FROM QUALITATIVE CHANGES OF PERSONALITY TRAITS SHOW MISTRUSTFULNESS, DETACHMENT, ANXIETY, APPREHENSIVENESS, OVERSENSITIVENESS AND ESTRANGEMENT FROM THEIR FELLOW-MAN. OTHERS SHOW MASOCHISTIC TENDENCIES WITH EXPLOSIVE AGGRESSIVE OUTBURSTS, A SENSE OF LONELINESS AND PESSIMISM AND SELF-DEFEATISM, WHICH CONTRIBUTE TO THEIR FALL TO A SOCIOECONOMIC STATUS LOWER THAN THEY ENJOYED BEFORE THE WAR (42). IN ALL CASES ONE QUESTION RECURS: IS THE BREAKDOWN CHIEFLY RELATED TO THE SEVERITY OF STRESS OR TO THE PRE-EXISTING PERSONALITY?

THE CONDITIONS WHICH THREATEN SURVIVAL (PATHOGENIC ENVIRONMENT) IN DEGREE OF SEVERITY ARE AS FOLLOWS—LOSS OF CIVIL RIGHTS, SEPARATION, SOCIAL INJUSTICE, STARVATION, DEFAMATION AND CALUMNY, LOSS, DISCRIMINATION, BOMBING, PERSECUTION (3), HORROR SCENES, OSTRACISM, EXPOSURE TO COLD, CAPTIVITY, BRUTALITY AND A THREAT TO LIFE AND SELF-ESTEEM.

THE RESULTING PSYCHOLOGICAL AND SOCIAL DISABILITIES ARE SUPPORTED BY PNEUMOENCEPHALOGRAPHIC STUDIES AND PSYCHOLOGICAL TESTING, AND THESE HAVE SHOWN DIFFUSE CORTICAL ATROPHY ASSOCIATED WITH A MILD ORGANIC BRAIN SYNDROME IN MORE THAN 90% OF THE SURVIVORS. THIS IS PROBABLY DUE TO PROLONGED SEMI-STARVATION (14).

SURVIVAL SYNDROME

NIEDERLAND (30) COINED THE TERM 'SURVIVOR SYNDROME' TO DESCRIBE THE VICTIMS OF RACIAL PERSECUTION AND CONCENTRATION CAMPS. THE MAGNITUDE, DURATION AND TYPE OF TRAUMATIZATION LEAVES AN INDELIBLE IMPRINT ON THE PERSONALITY. NIEDERLAND WLSO NOTED TYPICAL 'RE-RUN' NIGHTMARES, FEAR OF FALLING ASLEEP, LIVING-CORPSE APPEARANCE, CHRONIC DEPRESSION AND VARIOUS PSYCHOSOMATIC COMPLAINTS.

THE FOLLOWING CLINICAL EXAMPLE MAY SERVE TO ILLUSTRATE THIS SYNDROME. A 50 YEAR-OLD MALE ENTERED THE AUTHOR'S OFFICE WITH A SAD, APPREHENSIVE LOOK, REACTING TO ORDINARY NOISES (DOORS, CREAKS, TELEPHONE, VOICES) WITH A SUDDEN STARTLE AND DISPLAYING VARIOUS SIGNS OF INCREASED AUTONOMIC ACTIVITY—PERSPIRATION, SLIGHT TREMOR OF THE FINGERS, INTERMITTENT COLDNESS OF THE HANDS, PERIODIC DIARRHEA, INSOMNIA, UNSTABLE HYPERTENSION, TACHYCARDIA AND PALLOR. THESE SYMPTOMS PERSISTED IN SPITE OF CONTINUOUS INVESTIGATIONS AND THERAPY BY SEVERAL PHYSICIANS FOR NEARLY TWENTY YEARS. HE COMPLAINED PITEOUSLY OF HEADACHES, FATIGUE, WEAKNESS, FEAR OF THE FUTURE, INABILITY TO ENJOY LIFE, NIGHTMARES OF PERSECUTORY SCENES (WHICH OCCURRED FROM 1933 UNTIL HE ABSCONDED TO BRITAIN WITH HIS SISTERS IN 1939), RUMINATION OVER THE PAST, WITH A SENSE OF FUTILTY, LACK OF CONCENTRATION AND FORGETFULNESS.....

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NEUROLOGICAL ASPECTS OF BLAST EXPLOSIONS

Harold Elliott, M.D., Canadian Service Med. J. Vol. 10 (Sept. 1954)

BLAST SYNDROME VERSUS COMBAT EXHAUSTION

BECAUSE OF THE CONTROVERSIAL NATURE OF BLAST INJURY IN ITS RELATIONSHIP TO CONCUSSION AND CONCUSSION NEUROSIS AND SHELL SHOCK, THE FIRST AND NINTH UNITED STATES ARMIES MADE ARRANGEMENTS IN NOVEMBER, 1944, TO REFER PATIENTS WITH BLAST INJURY FROM THE COMBAT ZONE TO A SPECIAL HOSPITAL IN THE ROER-RHINE AREA. THEY TRIED TO INVESTIGATE WHETHER THE BLAST INJURY SYNDROME EXISTS, ITS CLINICAL MANIFESTATIONS, ITS PATHOGENESIS AND OTHER FACTORS. THEY SOON WERE ABLE TO SORT OUT A GROUP OF PATIENTS FROM A LARGER CLASSIFICATION OF SOLDIERS WITH ACUTE COMBAT EXHAUSTION. IT WAS FOUND THAT BLAST INJURY VARIED WITH THE TACTICAL SITUATION, AND IS IN ALL LIKELIHOOD AN INDEX OF THE EFFECTIVENESS OF THE ENEMY'S ARTILLERY. IT APPEARED TO BE OBLIVIOUS OF RANK. THERE SEEMED TO BE NO SPECIFICATION ABOUT THE TYPE OF EXPLOSION CAUSING BLAST INJURY. THERE WAS A SHORT PERIOD OF RETROGRADE AMNESIA AND A LONGER PERIOD, USUALLY AN HOUR, OF POST-TRAUMATIC AMNESIA. HEADACHE WAS CHARACTERISTIC; IT WAS USUALLY FRONTAL OR TEMPORAL, BUT THERE WERE COMBINATIONS AND SOMETIMES OCCIPITAL HEADACHE. TINNITUS WAS ALMOST A UNIVERSAL COMPLAINTS, AND IN SOME CASES WAS CHRONIC AND PROLONGED. THE SENSITIVITY TO NOISE WAS PITIABLY ACUTE. THE ANXIETY SYMPTOMS WERE THE SORT MET WITH IN OTHER NEUROSES OF COMBAT—VERTIGO, SEVERE BATTLE DREAMS, SUBJECTIVE FEELING OF TREMULOUSNESS—AND THERE WAS A LACK OF NORMAL ANIMATION.

KRAMER, REPORTING ON A SIMILAR GROUP OF PATIENTS, CAME TO THE CONCLUSION THAT THIS WAS A TRUE ENCEPHALOPATHY. THE DEATH OF ONE PATIENT THREE MONTHS AFTER THE INJURY, HE FELT, WAS THE RESULT OF LATE COMPLICATION OF THE BLAST SYNDROME. HE REPORTED THE ELECTROENCEPHALOGRAPHIC FINDINGS IN 441 LATE CASES, AND EVIDENCE FROM THE ABNORMAL BRAIN WAVES WAS ADDUCED TO INDICATE THE ORGANIC BASIS FOR THIS CONDITION.

CONCLUSION..... THE NEUROLOGICAL SEQUELAE IN TERMS OF EPILEPSY, MENTAL DETERIORATION, SPACE-OCCUPYING LESIONS (SUBDURAL HAEMATOMATA, INTRACEREBRAL HAEMORRHAGES OF VARYING SIZE AND SITUATION), POST-TRAUMATIC HEADACHE, TINNITUS AND MARKED SENSITIVITY TO NOISE ARE ALL WITHIN THE REALM OF POSSIBILITY AND MERELY REQUIRE CLINICO-PATHOLOGICAL CORRELATION FROM THE LONG-TERM VIEWPOINT.

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REPATRIATED AMERICAN POWs WITH SPECIAL REFERENCE TO AVITAMINOSIS, TUBERCULOSIS & INTESTINAL PARASITES by Colonel H.C. Gibson,MC; Maj. Henry A. Segal, MC; * Maj. Jakub G. Schlichter, MC. Med. Bull. U.S.Army, Far East, Vol. 1 (Aug. 1953). KOREA

DURING OPERATION "LITTLE SWITCH," 67 OF THE 149 AMERICAN SOLDIERS REPATRIATED FROM THE STOCKADES OF NORTH KOREA WERE RECEIVED AT THIS HOSPITAL (U.S. ARMY HOSPITAL, 8167th Army Unit, APO 1055).....

PSYCHOLOGICAL TESTING

THE GROUP WAS OF AVERAGE INTELLIGENCE. THE MEAN I.Q. AS DETERMINED BY THE WECHSLER-BELLEVUE WAS 103.

IN GENERAL, THE BENDER-GESTALT REPRODUCTIONS WERE REGRESSED. INEPT PRODUCTION, WITH ANXIETY SCHIZOID PICTURES AND POSSIBLE ORGANIC INVOLVEMENT WERE PROMINENT. SIMILARLY, THE DRAW-A-PERSON TESTS WERE REGRESSED AND SCHIZOID. THERE WERE MANY DISTORTED AND AMPUTATED FIGURES, PARTICULARLY AMONG THE AMPUTEES.

THE MIOLE-HOLSOPPLE TEST INDICATED IMPULSIVITY OR "ACTING OUT" UNDER STRESS. THINKING, IN MANY INSTANCES, WAS AUTISTIC AND FANTASTIC. ATTITUDES CONCERNING THE FUTURE WERE HIDDEN BY A PHANTASY-LIKE PROTECTIVE MECHANISM WITH FAILURE TO PROPERLY TEST REALITY. MANY REVEALED STRONG FEELINGS OF REJECTION DURING CHILDHOOD, FAULTY FATHER-FIGURE RELATIONSHIPS AND EVIDENCES OF FEAR CONCERNING THEIR ABILITY TO HANDLE FEELINGS OF HOSTILITY.

THE RORSCHACH PROTOCOLS REVEALED AN ABNORMALLY SMALL NUMBER OF RESPONSES AND A GENERAL TENDENCY TOWARD PSYCHOPATHIC CONTENT.

CLINICAL OBSERVATIONS

ALL OF THESE PATIENTS INITIALLY SHOWED A REACTION OF DULLNESS, APATHY AND RETARDATION WHICH LASTED FOR APPROXIMATELY THREE DAYS. DURING THIS PERIOD THE PATIENTS DISCUSSED OBVIOUSLY EMOTIONALLY CHARGED MATERIAL WITH BLAND INDIFFERENCE. THEIR TALK WAS SHALLOW AND VAGUE AND THERE WAS A DEFINITE LACK OF CONTENT TO THEIR PRODUCTIONS. GREAT GAPS WERE EVIDENT AND THERE WAS AN APPRECIABLE LACK OF SENSE OF TIME. THERE WAS LITTLE SPONTANEOUS TALK OF HOME OR FAMILY, AND THERE WAS NO APPARENT CONCERN FOR THE FUTURE. SUCH PLANS AS WERE OFFERED WERE POORLY CONCEIVED, OF A SHORT-TERM NATURE AND HIGHLY UNREALISTIC. AS THE APATHY SPONTANEOUSLY CLEARED, THERE WAS A NOTICEABLE INCREASE IN THE AMOUNT OF PERSONAL INTEREST EACH INDIVIDUAL DISPLAYED. THERE THEN BEGAN A DEMAND FOR HAIR TONIC, AFTER-SHAVE LOTION, SOUVENIRS, AND OTHER LUXURY ITEMS TO WHICH AT FIRST THEY HAD BEEN INDIFFERENT. IT WAS NOTED THAT PRONOUNCED ANXIETY REGARDING RETURN HOME WAS MANIFESTED BY A LARGE NUMBER OF PRISONERS. IN INSTANCES THIS ANXIETY WAS MASKED BY RATIONALIZATIONS SUCH AS, "I'M IN A HURRY TO GET HOME.....BUT FIRST I'D LIKE TO GET MY TEETH FIXED AND I'D LIKE TO GET NEW EYEGLASSES." IT WAS RECOGNIZED THAT SEVERAL SPECIFIC PROBLEMS WOULD CONFRONT THE GROUP UPON THEIR RETURN HOME. "THE HERO FOR A DAY SITUATION" IN WHICH MUCH ATTENTION AND PERMISSIVENESS IS ACCORDED THE RETURNEE FOR A LIMITED PERIOD OF TIME CREATED DEPENDENT DEMANDING INDIVIDUALS OF MANY WORLD WAR II REPATRIATES WHO CAME TO EXPECT THIS TREATMENT AS A MATTER OF COURSE. THE PROBLEM OF WHAT TO DO WITH THE LARGE SUM OF BACK PAY WILL BE A PRESSING ONE. ALSO, THE POW AND HIS FAMILY AND FRIENDS WILL TEND TO REMEMBER ONE ANOTHER AS THEY WERE TWO AND ONE-HALF YEARS AGO, RATHER THAN AS THEY ACTUALLY ARE. REINTEGRATION INTO THIS SMALL GROUP IS DIFFICULT. THE SEEMING INDIFFERENCE TO THE KOREAN CONFLICT OF LARGE ELEMENTS OF THE POPULATION MAY PRESENT A SERIOUS PROBLEM TO THE RETURNEE WHO IS GIVEN TO BELIEVE HIMSELF A "HERO". IN ADDITION, THE POW WILL BE CONFRONTED BY PEOPLE FOR WHOM HE MAY FEEL CONTEMPT BECAUSE OF THEIR EXPRESSIONS OF PITY OR CURIOSITY.

IN AN ATTEMPT TO DEAL WITH THESE PRACTICAL PROBLEMS, RANDOM GROUPS OF 6-10 REPATRIATES WERE SELECTED TO PARTICIPATE IN GROUP PSYCHOTHERAPY SESSIONS. AT FIRST THEY APPEARED SOMEWHAT APPREHENSIVE AND SUSPICIOUS. VERBALIZATIONS WERE SPARSE AND THERE WAS CONSIDERABLE APATHY. IT BECAME NECESSARY TO STRUCTURE THE SEEESIONS BY HAVING THE MODERATOR DISCUSS A SPECIFIC PROBLEM, SUCH AS FUTURE PLANS FOR THE SPENDING OF BACK PAY. ONLY THEN DID THE GROUP SHOW INTEREST AND VERBALIZE. THE TOPIC WAS GRADUALLY BROADENED IN SCOPE TO COVER THE PROBLEMS LISTED ABOVE. OUTSTANDING IN THESE DISCUSSIONS WERE THE POOR REALITY TESTING AND THE TENDENCY TO WITHDRAW INTO PHANTASY. IT WAS NOT FELT THAT SUFFICIENT TIME WAS AVAILABLE TO WORK-THROUGH MANY OF THE SPECIFIC ANXIETIES ENCOUNTERED.

CLINICAL DIAGNOSES

OF THE TOTAL GROUP, 122 (81%) WERE DIAGNOSED AS HAVING NO CLINICAL EVIDENCE OF SIGNIFICANT PSYCHIATRIC DISABILITY. IN THE REMAINING 27 CASES THE DIAGNOSES MADE ARE LISTED IN THE FOLLOWING TABLE:

PSYCHIATRIC FINDINGS IN 149 REPATRIATED PRISONERS

PARANOID SCHIZOPHRENIC REACTION	1
LATENT SCHIZOPHRENIC REACTION	1

PSYCHOTIC-DEPRESSIVE REACTION		1
PSYCHONEUROTIC REACTIONS		8
ANXIETY REACTION	(3)	
DISSOCIATIVE REACTION	(2)	
NEUROTIC-DEPRESSIVE REACTION	(2)	
SOMATIZATION REACTION	(1)	
IMMATURITY REACTIONS		7
SCHIZOID PERSONALITY	(5)	
CYCLOTHYMIC PERSONALITY	(1)	
PASSIVE-DEPENDENT REACTION	(1)	
NON-PSYCHOTIC MENTAL DISORDER W/PHYSICAL ETIOLOGY		4
TRAUMATIC BRAIN DAMAGE	(3)	
MALNUTRITION	(1)	
TRANSIENT PERSONALITY DISORDER		2
MENTAL DEFICIENCY		
(VERTIFIED PYSCHOLOGICAL IN ONE CASE)		3

CONCLUSIONS AND SUMMARY .....

A COMPLETE NEUROPSYCHIATRIC EVALUATION WAS ACCORDED THE 149 U.S. MILITARY REPATRIATED PRISONERS OF WAR ADMITTED TO THE 8167TH ARMY HOSPITAL AND TOKYO ARMY HOSPITAL.

ONE HUNDRED TWENTY-TWO (122) OR 81% WERE DIAGNOSED AS HAVING NO CLINICAL EVIDENCE OF SIGNIFICANT PSYCHIATRIC DISABILITY.

PSYCHOLOGICAL TESTING DISCLOSED THAT THE GROUP WAS OF AVERAGE INTELLIGENCE (I.Q. 103). IN GENERAL, PSYCHOLOGICAL TESTS REVEALED REGRESSION, APATHY, AND RETARDATION WITH A GENERAL TENDENCY TOWARD PSYCHOPATHIC CONTENT.

CLINICALLY, THE GROUP WAS INITIALLY APATHETIC AND REGRESSED BUT CLEARED IN APPROXIMATELY THREE DAYS AT WHICH TIME INTEREST IN THE ENVIRONMENT WAS NOTED.

THE USE OF GROUP PSYCHOTHERAPY SESSIONS IN AN ATTEMPT TO DEAL WITH FUTURE PROBLEMS OF THE REPATRIATES WAS BRIEFLY DISCUSSED.

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CANADIAN PENSION COMMISSION MEDICAL GUIDELINES, POW, JAPAN (MAY 7, 1976)

NEUROLOGICAL—(SUBJECTIVE & OBJECTIVE)—DISTRESSING PARESTHESIA, WEAKNESS & ATROPHY OF MUSCULAR TISSUE DURING CAPTIVITY WERE FOLLOWED BY A PARESTHESIA OF FEET & LEGS DESCRIBED AS "HOT FEET". THERE WAS IMPAIRMENT OF SENSATION OF COLD;WITH SOME CASES OF FROST-BITE RESULTING, REQUIRING A NUMBER OF SYMPATHECTOMIES. IT WAS COMMON PRACTICE TO LEAVE THE FEET UNCOVERED AT NIGHT. THIS TYPE OF SYMPTOM, COMMONLY MENTIONED AT FIRST, IS PERHAPS LESS SEVERE NOW, BUT MANY PENSIONERS STILL HAVE THE SYMPTOMS. THE SYMPTOMS ARE AT LEAST AS DISTRESSING AS THOSE OF FOOT STRAIN, ARE NOT RELIEVED BY MEDICATION OR ARCH SUPPORTS AND DISTURB SLEEP. USUAL ASSESSMENT RANGE, 5% TO 10%. IMPAIRMENT OF SENSATION & FACILITY IN THE USE OF THE HANDS HAS BEEN DOCUMENTED BY DR. E.V. KRAL & ASSOCIATES OF MONTREAL. OTHER FINDINGS, DISTURBED BALANCE & ATAXIA ARE TAKEN INTO ACCOUNT WHEN THE ASSESSMENT IS BOING ESTABLISHED. BOTH OF THESE SYMPTOMS VALIDATE THE CONCEPT OF WIDESPREAD NEUROLOGICAL DAMAGE.....

PSYCHIATRIC—MOST, IF NOT ALL, MEN RETURNING FROM JAPANESE CAPTIVITY TOOK LONGER TO RE-ADJUST TO CIVILIAN LIFE THAN OTHER VETERANS. THIS HAS BEEN SHOWN BY MORE THAN USUAL DIFFICULTIES IN SOCIAL AND ECONOMIC ADJUSTMENTS.

IMPAIRED TOLERANCE TO THE STRAINS OF DAILY LIFE ASSOCIATED WITH ANXIETY, TENSION & DE-PRESSION ARE MUCH COMMONER AND MORE SEVERE IN THESE VETERANS THAN IN ANY OTHER LARGE POPULATION OF VETERANS. CORROBORATION OF THIS POINT OF VIEW COMES FROM A STUDY OF AMERICAN & AUSTRALAIN PRISONERS-OF-WAR BOTH IN JAPAN AND KOREA.

THE NEUROPSYCHIATRIC DISABILITY IS ASSESSED WITHOUT RULING IN MOST CASES UNDER THE DIA-GNOSIS OF AVITAMINOSIS WITH RESIDUAL EFFECTS, PARTICULARLY WHERE THE DIAGNOSIS IS IN DOUBT, ASSESSMENT IS MADE IN ACCORDANCE WITH THE TABLE OF DISABILITIES FOR NEURO-PSYCHIATRIC CONDITIONS.....

NERVOUS CONDITIONS—PSYCHOTIC ILLNESS IS THE ONLY AREA OF NERVOUS DISEASE THAT REQUIRES A RULING, AND THIS IS NECESSARY ONLY WHEN UNDOUBTED PSYCHOTIC ILLNESS IS PRESENT. ALL OTHER NERVOUS CONDITIONS ARE ASSESSED WITHOUT RULING UNDER THE PSYCHIATRIC COMPONENT OF AVITAMINOSIS WITH RESIDUAL EFFECTS.

AS WITH ALL PENSIONERS, A P.O.W. OF THE JAPANESE MAY CLAIM FOR ANY OTHER CONDITION ON A CONSEQUENTIAL BASIS WHICH HE CONSIDERS IS RELATED TO THE AVITAMINOSIS WITH RESIDUAL EFFECTS. SUCH CLAIMS WILL BE CONSIDERED ON THEIR INDIVIDUAL MERITS.

ROY LESS EMKEN, M.D., NEUROPSYCHIATRY, UNIVERSAY OF TEXAS MEDICAL BRANCH, GALVESTON, TX WRITES THAT ALL EX-POW's OF THE JAPANESE HAVE AS A GENERAL RULE; MARCH 17, 1977

1. TRAUMATIC NEUROSIS WITH BATTLE DREAMS. THIS GENERALLY CAN BE PICKED UP WITH A PSYCHIATRIC INTERVIEW.

2. RESIDUAL BRAIN DAMAGE, THIS REQUIRES EEG PROBABLY WITH NP LEADS: BRAIN SCAN WITH PERFUSION AND EMI SCAN.

3. RESIDUAL BERIBERI—A NEUROLOGICAL CONSULTANT CAN PICK UP THE RESIDUAL PERIPHERAL NEUROPATHY.

KZ SYNDROME LONG-TERM EFFECTS

By Anne-Lise Gotzsche, GP February 4, 1972

THE LONG TERM EFFECTS OF WARTIME DEPRIVATION HAVE BEEN FOLLOWED UP BY DR. PAUL THYGESEN, PROFESSOR IN NEUROLOGY AT THE GENTOFTE HOSPITAL IN COPENHAGEN, AND HIMSELF A FORMER RESISTANCE WORKER AND PRISONER IN GERMAN CONCENTRATION CAMPS. WITH KNUD HERMANN AND ROLF WILLANGER HE PUBLISHED LAST YEAR A PAPER ON THE SUBJECT IN THE DANISH MEDICAL BULLETIN

THE 'KZ SYNDROME' (CONCENTRATION CAMP SYNDROME) HAS BEEN DESCRIBED AS A STATE OF CHRONIC AND OFTEN DISABLING BODILY AND MENTAL WEAKNESS, INCLUDING EMOTIONAL DISTURBANCE, PROGRESSIVE INTELLECTUAL REDUCTION, REDUCED POTENCY, OCULAR DISTURBANCES, DECREASE IN RESISTANCE TO INFECTIONS, STRESS-PRODUCED HYPOTHALAMIC DYSFUNCTION, PREMATURE SENESCENCE, ORGANIC BRAIN DAMAGE AND CEREBRAL ATROPHY.

IT WAS NOT TILL EIGHT YEARS AFTER THE WAR THAT THE SYMPTOMS WERE INTERNATIONALLY ACCEPTED AS A DEFINITION BY THE MEDICAL PROFESSION - ONE OF THE CAUSES OF THE EARLY DELAY IN COMPENSATION.

THE SYNDROME IS NOT NECESSARILY STATIC, AND IT WAS SEEN IN ITS 'PUREST' FORM 5-10 YEARS AFTER LIBERATION. IN THOSE WHO ARE NOW AROUND 60 YEARS OF AGE, FATIGUE, PERIODIC DIARRHOEA, GASTRIC DYSPEPSIA, ULCERS, HOT FLUSHES, ATTACKS OF SWEATING, PALPITATIONS, FUNCTIONAL DYSPNOEA, DIZZINESS, AND DISTURBANCES OF SLEEP AND NIGHTMARE ARE COMMON.

MENTAL SYMPTOMS INCLUDE DEPRESSION, INCREASED SENSIBILITY TO NOISE, IRRITABILITY AND ATTACKS OF RAGE, OVERREACTION, EMOTIONAL INCONTINENCE, AND A GENERAL 'PERSECUTION' SYNDROME.

IN OTHER CASES THERE MAY BE COMPLETE APATHY AND HELPLESSNESS, TOGETHER WITH A HIGH CONSUMPTION OF ALCOHOL.

REDUCTION OF THE POWERS OF CONCENTRATION, PROGRESSIVE DETERIORATION OF MEMORY, AND DISTURBANCE IN LANGUAGE FUNCTIONS ARE COMMON.

IN SOME PATIENTS THERE IS ALSO 'SURVIVAL GUILT' - THEY CANNOT GIVE UP THEIR SYMPTOMS BECAUSE THIS WOULD MEAN THAT THEY HAD FORGOTTEN THEIR DEAD AND WERE UNFAITHFUL TO THEIR MEMORY.

WITH ALL THESE SYMPTOMS THERE MAY BE A LATENT PERIOD, OFTEN LASTING YEARS, ESPECIALLY IN THE OLDER AGE GROUPS. BUT THIS IS ALSO FOUND AMONG THOSE WHO WERE YOUNG DURING THE WAR AND FOUND IT EASIER AT FIRST TO COMPENSATE FOR FATIGUE AND IMPAIRED INTELLECTUAL FUNCTIONS.

THYGESEN PUTS IT THIS WAY: 'THE SURVIVOR CAME HOME AS A HERO - A THIN HERO, STILL WITH DIARRHOEA. THE SUMMER OF THE LIBERATION GAVE HIM A SUNTAN AND HE APPARENTLY QUICKLY PUT ON FLESH. NOW HE HAD TO PULL HIMSELF TOGETHER.....'.