Post Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a mental health condition that can develop after an individual experiences or witnesses a traumatic event. From a medical and psychiatric perspective, PTSD is characterized by a range of symptoms that can have a significant impact on an individual's daily life and overall well-being.

Symptoms of PTSD can be divided into four main categories:

1. **re-experiencing the traumatic event.**
2. **avoidance of reminders of the event.**
3. **negative changes in mood and cognition.**
4. **increased arousal and reactivity.**

Re-experiencing symptoms include nightmares, flashbacks, and intense feelings of distress when reminded of the traumatic event. Avoidance symptoms include avoiding people, places, or activities that remind the individual of the traumatic event. Negative changes in mood and cognition include feeling detached, feeling guilty, or ashamed, having negative thoughts about oneself or others, and feeling hopeless about the future. Increased arousal and reactivity symptoms include being easily startled, feeling irritable or angry, and having difficulty sleeping.

From a psychiatric perspective, PTSD is considered to be an anxiety disorder. It is thought that the traumatic event disrupts the normal processes of fear extinction and memory consolidation, leading to the persistence of fear and traumatic memories. Research suggests that changes in the structure and function of certain brain regions, including the amygdala and the hippocampus, may contribute to the development of PTSD.

Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) outlines the diagnostic criteria for post-traumatic stress disorder (PTSD) as follows:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic

event(s), beginning after the event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Inability to remember an important aspect of the traumatic event(s) (typically due to dissociation).
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
- Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Inability to experience positive emotions (e.g., inability to experience happiness, satisfaction

Shell Shock

“Shell shock” is a term that was first used during World War I to describe the psychological symptoms experienced by soldiers as a result of exposure to combat. The term referred to the idea that the symptoms were caused by the physical effects of explosions, or “shells,” on the brain.

The symptoms of shell shock were varied and included things like anxiety, depression, nightmares, flashbacks, irritability, and physical symptoms such as tremors or fatigue. Soldiers experiencing shell shock were often withdrawn, confused and unable to perform basic functions. They were also often seen as “cowards” by their comrades and military authorities.

At the time, there was little understanding of the psychological effects of combat and many soldiers with shell shock were treated harshly, including being court-martialed, imprisoned or sent back to the front lines.

As more and more soldiers began to experience shell shock, the British Army began to establish specialized hospitals to treat these soldiers. Medical professionals at these hospitals began to understand that shell shock was not a physical injury, but a psychological one, caused by the trauma of warfare.

During World War I, the treatment of shell shock varied widely and was often ineffective. Many soldiers with shell shock were treated harshly and were seen as malingerers or cowards. Some soldiers were court-martialed, imprisoned, or sent back to the front lines.

As the war progressed, the British Army began to establish specialized hospitals to treat soldiers with shell shock. Medical professionals at these hospitals began to understand that shell shock was not a physical injury, but a psychological one caused by the trauma of warfare.

In these hospitals, a variety of treatment methods were used, including:

- Rest and recuperation: soldiers were removed from the front lines and given time to recover in a peaceful environment
- Occupational therapy: soldiers were given tasks to complete such as woodworking or farming to keep them occupied and to aid in their recovery
- Psychotherapy: soldiers were encouraged to talk about their experiences and feelings related to the trauma.
- Electroconvulsive therapy (ECT) and Insulin shock therapy: Both were used as a last resort to treat soldiers who were unresponsive to other treatments.
- Morphine and other sedatives: these drugs were used to help soldiers sleep and reduce their symptoms of anxiety and depression.

It is important to note that these treatments were not always effective, and many soldiers with shell shock did not fully recover. Additionally, the treatments were often harsh and invasive and did not take into account the psychological and emotional needs of the soldiers.

After the war, the term “shell shock” fell out of use and was replaced with the term “war neurosis” and later “combat stress reaction” and “post-traumatic stress disorder (PTSD)”. The understanding of PTSD has greatly developed since the first world war, and the treatments for it have improved significantly as well.

Vietnam War Veterans

During the Vietnam War, it is estimated that approximately 2.7 million American soldiers served in the conflict. After the war, a significant number of Vietnam War veterans experienced difficulty adjusting to civilian life and experienced a range of mental health issues, including post-traumatic stress disorder (PTSD). As a result, many Vietnam War veterans ended up in prison.

It is difficult to determine the exact number of Vietnam War veterans who were incarcerated after the war. The Department of Veterans Affairs (VA) has reported that as of 2016, around 30% of Vietnam War veterans were incarcerated, but this number may not be entirely accurate as it is difficult to track veterans who may not have sought help from the VA.

One of the main reasons that many Vietnam War veterans ended up in prison was due to their struggles with PTSD and related issues such as substance abuse and homelessness. After experiencing the trauma of combat, many veterans had difficulty adjusting to civilian life and turned to drugs or alcohol to cope. This often led to addiction, which in turn led to legal problems and involvement with the criminal justice system.

Additionally, many veterans struggled with mental health issues such as depression, anxiety, and anger, which made it difficult for them to hold down a job or maintain relationships. This could lead to a range of issues that would eventually lead to criminal activities.

It is worth noting that, since the Vietnam War, the US government, the Department of Veterans Affairs, and veteran organizations have increased their efforts to help veterans with their reintegration into society and to provide support for those suffering from PTSD and other mental health issues. These efforts include providing veterans with counseling, therapy, and other forms of mental health support, as well as job training and education programs.

Homelessness Among British Gulf War Veterans

The rate of homelessness among British veterans from the Gulf Wars (1990-1991 and 2003-2011) is a complex issue and there is no clear consensus on the exact numbers. Studies have shown that veterans are over-represented among the homeless population in the United Kingdom, but it is not clear to what extent this is specifically true for Gulf War veterans.

Some estimates suggest that around 10% of the homeless population in the UK are veterans, with a proportion of those being Gulf War veterans. However, the true number is likely to be higher as many veterans who are homeless do not self-identify as such, making it difficult to get an accurate count.

There are a variety of factors that contribute to veterans experiencing homelessness, including mental health issues such as PTSD and depression, as well as issues related to substance abuse and difficulty transitioning to civilian life.

The UK government and veterans' organizations have taken steps to address the issue of homelessness among veterans, including providing housing and support services, and outreach programs to help veterans access these services. Additionally, the Veterans UK, a government department, provides a range of services to veterans including housing and financial assistance to veterans who are homeless or at risk of becoming homeless.

It's worth noting that the UK has a duty to provide housing to its veterans who are homeless or at risk of becoming homeless under the Homelessness Reduction Act 2017. The act makes it a legal duty for local authorities to provide assistance to veterans who are homeless or at risk of becoming homeless.