Opinion: How context makes conflict trauma hard to understand, and not just for Trump

October 10 2016, by Mark De Rond

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When US presidential hopeful Donald Trump jumped with characteristic abandon into the debate over post-traumatic stress disorder, his comments that some veterans are not "strong enough" to handle the mental stresses of combat were broadly criticised. War veterans, and the media, were quick to respond, many (though not all) furious at the Republican nominee's ignorance of, and insensitivity towards, a complex injury that affects many. Psychological injury, after

all, is rarely a private affair, with families, friends, and colleagues at the receiving end of depressive bouts, violence and substance abuse.

How bad is the problem? The US Department of Veteran Affairs says that about a quarter of the 2.7m US troops sent to Iraq or Afghanistan in the 2001-2011 period returned home with some psychological injury. The last 20 years in Britain has seen a four-fold increase in former service personnel seeking help for mental disorders, according to the charity Combat Stress.

It has long been assumed that war-related PTSD stems from how well a person copes psychologically with exposure to the threat and the reality of violence. While exposure to terrible events is clearly an important trigger of PTSD, it may only tell part of a more complex story.

My 16 months of fieldwork – including a six-week tour of duty – with military doctors during the most recent war in Afghanistan may help to pick it apart. I was surprised to discover that the context through which wars are experienced – and specifically the professional, cultural and organisational context through which people frame their daily experiences – may be just as important in determining who will likely suffer from PTSD and who will not. The research was conducted with Jaco Lok of the University of New South Wales in Australia, and recently published in the *Academy of Management Journal*.

Medical values

Like other professionals, doctors have been socialised into a set of values by means of their training and experience. These values can collide with the realities of war. On multiple occasions, we discovered a clear dissonance between the values of the medical profession and the futility and senselessness experienced by doctors in wartime situations – regardless of whether or not they were directly exposed to combat. This

values-reality collision – even among battle-hardened medics – can contribute significantly to the experience of psychological injury.

To better illustrate how context relates to PTSD, it's useful to recount my experience at Camp Bastion in 2011. I was embedded with a team of "rear-located medics", mostly British or American, stationed away from the battlefield. Because they had less reason to fear for their lives than combat personnel, they were a good group to study factors beyond the psychological reaction to battle.

These doctors found some local rules very difficult to accept – particularly the requirement that badly mutilated children (often victims of improvised explosive devices encountered while playing) be quickly transferred from Camp Bastion's small field hospital to inferior local facilities to make way for battlefield casualties. Such rules ran counter to the doctors' purpose and values, amplifying feelings of senselessness and futility.

I recall two doctors expressing the frustration of bringing a stable, anaesthetised patient over to some hospital only to be met by an empty van where they had to hand over a casualty, on 60% oxygen and strong analgesics, to a driver with neither equipment nor experience. Practices such as these tore at the fabric of their professional purpose and responsibility and highlighted the contrast between the medics' actual experience in a warfare setting with their professional expectations as doctors – a life of "the meaningful, the good and the normal". This can have a sharply disorienting effect.

So the specific professional and cultural expectations through which doctors filter their experience of war can influence whether and how they experience war as psychologically traumatic. And what applies to doctors is likely to also apply to soldiers: each will interpret their experiences in a context particular to their culture, organisation, and

professional values.

Forced normality

To help them cope with experiences of futility, senselessness, and surreality, doctors typically import routines and rituals to restore their sense of normality: Friday night pizza, Sunday morning pancake breakfasts, cinema evenings, sports days, midsummer Christmas celebrations, a carefully tended sunflower patch behind the hospital, a non-alcoholic beer after work. While well-intended, these routines often made reality even more absurd.

When such disorientation is sustained over time, it can damage the ability of everyday rituals and routines to provide a sense of meaning and predictability to life back home. For example, to eat Pizza Hut pizza after emergency surgery on a child may forever taint any future experiences of Pizza Hut. Likewise, as happened during my time with the team, to see a nurse carrying an amputated leg to the incinerator only to run into a colleague dressed in bunny ears and carrying Easter eggs can create experiences of startling dissonance.

Imported routines are "soiled" by being experienced in a particular (and particularly alien) context. This may be one important reason why many war veterans find it so difficult to adjust back to home life. Life at war is very different from life back home, and recreating "home comforts" while on tour may not always be beneficial.

I make no claim to understand all the complexities of PTSD; much less provide all the answers. But a better understanding of context – an acceptance that psychological reaction to "war" goes far beyond mortars and bullets – may help improve the way mental health experts diagnose and manage mental injury stemming from wartime exposure. We owe our veterans, doctors included, that much at least.