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## Combat Trauma, Memory, and the World War II Veteran

**W**orld War II was certainly not the first war with veterans suffering from Post-traumatic Stress Disorder (PTSD) and related syndromes, or as it was known then, “combat fatigue.” Variants of this affliction have been chronicled ever since Homer. However, the presentation of this disorder in the WWII veteran frequently took a unique course, with symptoms appearing—or reappearing after a long period of dormancy—in mid-life. Also, the question of the veracity of memories, especially traumatic memories, from more than 65 years ago is of keen interest to historians.

These, and related issues, are especially important as the age of these veterans ranges from their late 80s to their 90s, with some even passing the century mark. According the Department of Veterans Affairs (Department of Veterans Affairs, 2008), of the more than 16,000,000 American men and women who wore the uniform during WWII, only 2,306,000 are alive today. That is less than 7%. Each day, we lose more. In another 10 years, there will be only a handful left.

### **PTSD**

What we now call “PTSD” was referred to by various names during different time periods, depending on what etiology was ascribed to it. In the civil war, it was “soldier’s heart.” In WWI, it was “shell shock”, and during WWII and Korea, it was

“combat fatigue.” The American Psychiatric Association coined the term “PTSD” in 1980, in the then current iteration of their diagnostic ‘bible’, DSM-III.

Current diagnostic criteria for a diagnosis of PTSD (American Psychiatric Association, 2000) are the following:

The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others, and his/her response involved intense fear, helplessness, or horror.

*Intrusive Recollection:* The event is persistently re-experienced in at least *one* of the following ways: Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions; recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated); intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

*Avoidance/Numbing:* Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least *three* of the following: Efforts to avoid thoughts, feelings, or conversations associated with the trauma; efforts to avoid activities, places, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; markedly diminished interest or participation in significant activities; feeling of detachment or estrangement from others; restricted range of affect (e.g., unable to have loving feelings); sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

*Hyper-arousal:* Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least *two* of the following: difficulty falling or staying asleep; Irritability or outbursts of anger; difficulty concentrating; hyper-vigilance; exaggerated startle response.

Duration of the disturbance is more than one month.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

It is important to note, however, that most psychiatric disorders are not real things—which is not to say that psychiatric symptoms do not hurt as much or cause as much disability as physical symptoms. They do not have the same existential status as, say, houses, cars, or cats. They are, to a certain extent, man-made: i.e., they are defined by a certain constellation of symptoms identified by professional associations and subject to a certain amount of subjectivity and political pressure. In part, this is why PTSD was not “officially recognized” until 1980.

Thus, we should recognize the existence of partial PTSD, or sub-syndromal PTSD, which is diagnosed when a person does not fully meet the criteria of PTSD, but has a significant number of symptoms which are clearly related to a psychological trauma and cause significant distress or impairment in social, occupational, or other important areas of functioning (See, e.g., Stein, et. al., 1997).

### **Prevalence of PTSD Among WWII Veterans**

It is difficult to determine the prevalence of PTSD among WWII veterans because the diagnostic criteria were not determined until 35 years after the war. Many WWII veterans with PTSD received such diagnoses as Anxiety Neurosis, Depressive Neurosis, Melancholia, Anti-social Personality, or even Schizophrenia because the correct diagnosis did not yet exist. I well remember reviewing the medical chart of a WWII B-17 gunner, who had been a POW of the Germans for several years, whose most prominent symptoms were anger, guilt, and olfactory “hallucinations” of smelling rubber burning and smoke, who was diagnosed with schizophrenia and psychiatrically hospitalized for over two years (Langer, 1987). It was only because his psychiatrist wrote such detailed notes that, to a later reader, it was abundantly clear he suffered from PTSD.

In discussing prevalence it is important to distinguish current prevalence from lifetime prevalence. Current prevalence measures those who meet the diagnostic criteria at the time of the survey; lifetime prevalence measures those who met the criteria at any time during their lifetime. Lifetime prevalence is usually higher than current prevalence. For example, lifetime prevalence of PTSD among the U.S. population is 6.8%, while current prevalence is 3.6% (National Comorbidity Survey, 2005).

The National Vietnam Veterans Readjustment Study, conducted 1986-88, is the largest study of combat veterans ever done: N=3,016. It found that lifetime prevalence of PTSD among Vietnam veterans was 31% for men and 27% for women. Current prevalence was 15% and 9% respectively. (Department of Veterans Affairs, 2007) However, a later analysis of the data (N=260, 11-12 years post-war) found a lower prevalence rate: 18.7% lifetime prevalence and 9.1% current prevalence. (Dohrenwend, et. al., 2006) These conflicting conclusions remain hotly contested among the mental health community. However, it is interesting to note that the Dohrenwend study, which found lower a prevalence of PTSD, noted a current prevalence 28.5% of combat-related sub-syndromal PTSD causing at least moderate difficulty in functioning.

A smaller study (N=357) of PTSD among WWII and Korean War ex-prisoners of war (ex-POWs) found a current prevalence rate of 26%-33%, depending on the assessment instrument used, although, curiously, some of these “report little distress associated with their symptoms, having reached some personal level of adjustment....” (Engdahl and Eberly, 1994)

McCloud (2000), studying 147 New Zealand WWII veterans receiving pensions for psychiatric disability, found 37% who met full DSM criteria, but 48% with severe symptoms attributable to their service more than 55 years prior, but who did not meet full DSM criteria. Thus, it is clear that combat-related PTSD and its sub-syndromal variants are often chronic conditions causing significant problems for those unfortunate enough to have them.

### **Delayed-onset PTSD**

For many WWII veterans, PTSD symptoms became prominent in midlife. There has been some question whether this phenomenon was an initial presentation of symptoms or a re-emergence of previous symptoms that had (partially) remitted. The evidence seems to be that in most cases, it is the latter situation. Port et. al. (2001), in a study of WWII and Korean ex-POWs, found that “symptoms were

highest shortly after the war, declined for several decades, and increased within the past two decades. Long-delayed onset of PTSD symptoms was rare.”

The more interesting question is why PTSD symptoms become more prominent in midlife. Port et. al. (2001) found that the most significant precipitant was retirement. However, my clinical observations lead me to think that, besides retirement, other precipitants include the deaths of friends, one’s own deteriorating health, children becoming autonomous, divorce, and other losses associated with aging. Other precipitants include current events that trigger memories of one’s own combat experience, e.g., 9-11, and other wars. The effect of the formal recognition of PTSD in 1980, as well as the widely reported experiences of Vietnam veterans may also have encouraged WWII veterans to speak about their symptoms.

Often, as one ages, one finds that he has too much time on his hands, leading to more focus on self. This can be positive if it leads to introspection and making peace with one’s life, but it is damaging if it leads to excessive regret and self-deprecating thoughts. A satisfying life must have meaning, and unfortunately for many of us that meaning is tied up in our work. A life without meaning leaves plenty of room for PTSD—as well as other psychiatric disorders, such as depression, anxiety, and substance abuse—to fill.

There is also anecdotal evidence that the WWII generation, for a variety of sociological reasons, downplayed the effects of their personal trauma. This generation lived through the Great Depression, and many individuals experienced severe deprivation and trauma prior to going to war. One might hypothesize that such pre-war experiences at least partially inoculated some individuals from the effects of combat-related trauma. (This may also help explain Engdahl and Eberly’s curious observation noted above.) The stigma of mental illness, and seeing a mental health professional, was quite strong, and the use of alcohol to deal with emotional pain was widely accepted. They were also conditioned not to complain about their hardships, so many combat veterans may have suffered in silence after their return from the war. They returned to a soon thriving economy, which may have distracted some combat veterans, at least temporarily, from their war experiences. The fact that WWII veterans returned home in victory may also have deterred them from reporting “negative” experiences and symptoms.

### **Combat-related Trauma**

As noted earlier, the first criterion for PTSD is that “(t)he person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself

or others, and his/her response involved intense fear, helplessness, or horror.” Combat-related trauma is unlike other forms of PTSD, in that it involves not only what happened to you, but also *what you did*. Maguen et. al. (2009) found that killing, compared with exposure to general combat experiences, is associated with more severe functional impairment.

The intent to kill and destroy is what makes combat-related trauma not only a psychological disorder, but also a psycho-spiritual disorder. (Tick, 2005) War wounds the soul. In war, our usual sense of morality is turned on its head, and what makes sense in wartime—maybe even is essential in wartime—may not make sense once one returns to civilian life. Morality is the foundation of all other values, and moral damage may affect any or all of the other value-dependent aspects of our lives, e.g., intimacy and love, the ability to appreciate beauty and pleasure, and our spiritual selves. Paradoxically, this is especially true for “good people” because the cognitive dissonance between their core moral beliefs and what they must do during wartime is that much greater.

Combat related trauma may lead to full-blown PTSD or partial PTSD. Common symptoms are depression, anxiety, guilt and/or shame, preoccupation with war-related subjects, substance abuse, and—most of all—anger. O’Donnell et. al. (2006), in a study of WWII ex-POWs, found that 60% reported verbal aggression and 12% physical aggression in their marriages.

### **Traumatic Memory**

Many combat veterans report vivid memories and dreams related to their combat experiences. These memories and dreams seem to be qualitatively different from ordinary memories, and they generally change very little over time. Such memories are often called “flashbulb memories” because of their special quality. “(T)he apparent immutability of traumatic memories have given rise to the notion that traumatic memories may be encoded differently from memories of ordinary events—perhaps because of alterations in the focusing of attention, or perhaps because extreme emotional arousal interferes with hippocampal memory functions.” (van der Kolk, 2007)

Traumatic memories are dissociated from the ordinary fabric of our lives, and that may be in part why they have the special ‘feel’ that they do. In fact, van der Kolk and Fisler (2005) performed “(a) systematic exploratory study of 46 subjects with PTSD (which) indicated that traumatic memories were retrieved, at least initially, in the form of dissociated mental imprints of sensory and affective elements of the traumatic experience: as visual, olfactory, affective, auditory, and

kinesthetic experiences. Over time, subjects reported the gradual emergence of a personal narrative that can be properly referred to as ‘explicit memory’.”

However, it is important to recognize that just because traumatic memories seem more vivid and immutable than ordinary memories does not mean that they are more accurate. In fact, there is some evidence (e.g., Telarico and Rubin, 2003) that they are no more accurate than ordinary memories, even though the subject perceives them as more accurate. It is not difficult to understand why people who experience such vivid and apparently immutable subjective experiences believe that their minds have virtually ‘photographed’ the traumatic scene, and for more than a hundred years most expert opinion supported such claims. Perhaps the fact that the pioneers in the study of such memories—Charcot and Janet—did their initial work at the same time that photography was being developed led to the objectification of the metaphor.

Curiously, it is the very fact of their special qualities—especially their vividness and the subject’s belief that they are exact representations of what they experienced—that proves that what is described by traumatized subjects is not a veridical account of what was experienced. In order to communicate what was experienced, the experiences must be transferred to declarative—or explicit—memory, i.e., the conscious awareness of what has happened, and in so doing the element of meaning, of interpretation of the raw data, is introduced into the mixture.

The irony is that although the sensory perceptions reported in PTSD may well reflect the actual imprints of sensations that were recorded at the time of the trauma, all narratives that weave sensory imprints into socially communicable stories are subject to condensation, embellishment, and contamination. Although trauma may leave an indelible imprint, once people start talking about these sensations and try to make meaning of them, they are transcribed into ordinary memories—and, like all ordinary memories, they are then prone to distortion. People seem to be unable to accept experiences that have no meaning; they will try to make sense of what they are feeling. Once people become conscious of intrusive elements of the trauma, they are likely to try to fill in the blanks and complete the picture. (van der Kolk, 2007)

It is the process of filling in the blanks by creating a personal narrative that integrates the dissociated percepts into the fabric of the veteran’s life. By telling his story the veteran gives it meaning, and in so doing gains control over his symptoms.

## Conclusions

Veterans of WWII, like combat veterans from wars before and since, suffer from a variety of traumatogenic disorders and co-morbid conditions. The precise prevalence of such conditions in WWII combat veterans is impossible to determine due to a number of factors, including the absence of diagnostic criteria until 35 years after the war ended, the wide variety of sub-syndromal varieties of PTSD, and the social climate that prevailed in the years after the war. However, by any reasonable measurement, the prevalence is substantial. Many of these veterans became symptomatic in middle age, and frequently their symptoms became chronic. The symptoms often are not just psychological, but psycho-spiritual, affecting the core of his being. It is not uncommon that these symptoms affect the veteran's most intimate relationships, often because he is unable to control his anger.

Remarkably, memories and dreams of the war remain vivid, even more than 65 years later. However, the vividness and subjective sense of their immutability does not necessarily prove their accuracy, since they are necessarily mediated by language and meaning. WWII veterans have adjusted to their symptoms through a variety of methods, some more functional than others. However, the long-lasting psychological damage experienced by some WWII combat veterans—and presumably combat veterans of other wars—is a cost of war that is seldom recognized by those for whom they fought, and it is a factor that should be considered in deciding whether to enter future wars.

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