Military Psychologists' Desk Reference

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PART IV

Clinical Theory, Research, and Practice
American former prisoners of war (POWs) are exceptional individuals. As many as 110,000 POWs were alive in the mid-1950s; at last estimate, less than 30,000 remained (US Department of Veterans Affairs, 2006). Roughly 25,000 were from World War II (WWII), 2,000 from Korea, 550 from Vietnam, and approximately 40 from the Cold War, Desert Storm, and subsequent conflicts combined. Very few remain on active duty. Nearly all were subjected to a spectrum of harsh abuse and suffered a myriad of insults, including malnutrition, exposure to environmental extremes, infections, and physical and emotional injuries (for further detail, see Skelton, 2002).

Postrepatriation treatment has always placed priority on restoring lost weight and treating medical illnesses and physical injuries. Following WWII and the Korean War, it was not uncommon during repatriation examinations for POWs to be told that their ordeal would shorten their life span, although the studies summarized by Beebe (1975) and Page (1992) showed increased morbidity and mortality only in the first postwar years. For all too many, their psychological injuries were only recognized in hindsight. Beebe proposed a model to explain negative captivity effects. They stem from two types of trauma: one is physical and primarily short-term, caused by malnutrition, infection, and physical injury; the other is psychological and essentially permanent, leading to a loss of “ego strength” and lowered thresholds for both physical and psychological distress.

Many POWs suffer from what we now know as post-traumatic stress disorder (PTSD), almost entirely traceable to combat and prison camp trauma. The psychological challenge of being held captive cannot be overemphasized; see Farber, Harlow, and West (1957) for their insightful discussion of the “three D’s” faced by POWs—debility, dependency, and dread.

PTSD is defined by an enduring set of maladaptive symptoms that arise after exposure to one or more potentially life-threatening events (see elsewhere in this volume). These symptoms include the unwanted reexperiencing of painful trauma memories—nightmares, daytime intrusive memories, and psychological distress and/or physiologic arousal when reminded of the trauma. Other symptoms include avoidance of trauma reminders, withdrawing from one’s environment, plus a numbing of responsiveness. Persistent arousal—sleep disturbances, irritability, exaggerated startle responses, and/or hypervigilance—also contributes to the functional impairments accompanying PTSD.

In a community sample of POWs (N = 262) from WWII and the Korean War, over half met lifetime criteria for PTSD, and 30% met criteria for current PTSD, 40 to 50 years after repatriation (Engdahl, Dikel, Eberly, & Blank, 1997). The most severely traumatized group—POWs held by Japan—had lifetime PTSD rates of 84% and current rates of 58%. In a
further study of this group (Dikel, Engdahl, & Eberly, 2005), over 50% of the variance in current PTSD severity was accounted for by a combination of prewar, wartime, and postwar factors. POW camp trauma was most predictive of PTSD severity, followed by a narrowly defined postwar social support variable: interpersonal connection. Prewar conduct disorder behavior positively predicted PTSD and negatively predicted interpersonal connection. Combat exposure and being younger at capture also predicted PTSD. Prewar family closeness did not predict PTSD, but predicted postwar interpersonal connection. This study provides strong evidence that trauma is by far the most significant predictor of PTSD severity and chronicity among POWs. Few of these men had ever sought mental health treatment. This is changing as DoD and the Department of Veterans Affairs continue their efforts to destigmatize mental health problems and encourage service members and veterans to seek treatment.

The long-lasting effects of combat and imprisonment are not universally negative. A narrow focus on negative effects blinds us to the complexity of responses to trauma, and the resilience that survivors exhibit. Post-traumatic growth is an important but often overlooked aspect of functioning among trauma survivors. World War II and Korean War POWS learned through their combat and prison camp trauma that they were stronger than they thought they were. They also developed a greater appreciation of life and personal relationships; many had positive growth in their spiritual lives (Erbes et al., 2006).

Research findings coupled with intense and persistent congressional lobbying have established a list of “presumptive” service-connected disabilities for POWs. If found, they are automatically presumed to be related to the POW’s military experience, without requiring historical written proof, qualifying the POW for care and disability benefits (Skelton, 2002). Many medical records were never generated, or were lost, leaving the POW with no way to prove a connection between wartime service and present-day illnesses. The “presumptives” initially included arthritis due to injury, any disease due to malnutrition, chronic dysentery, frostbite, helminthiasis (parasitic worms), psychosis, panic disorder, PTSD and other anxiety disorders, depression, peripheral neuropathy (nerve damage), irritable bowel syndrome, and peptic ulcer disease. Subsequent research and lobbying led to the addition of ischemic heart disease, cirrhosis, stroke, and osteoporosis.

OPERATION HOMECOMING AS A MODEL FOR POW REPATRIATION

In contrast to the unorganized, sometimes indifferent reception afforded repatriated POWs from previous wars, Operation Homecoming was conducted in the Philippines for repatriated Vietnam POWs in February–March 1973 (Ursano & Rundell, 1989). Safeguards included carefully balanced diets and insulation from the press. A man of equivalent rank, service branch, and background greeted each POW and served as an escort, a buffer, and a source of support. He provided up-to-date information about the world and the POW’s family. Navy Captain Jeremiah Denton’s first words upon landing were: “We are honored to have had the opportunity to serve our country under difficult circumstances. We are profoundly grateful to our Commander in Chief and to our nation for this day. God bless America” (Sterba, 1973).

CURRENT RESOURCES

At the service branch level, resources such as the USAF’s Family Readiness Edge applies to all deployed service members including POWs, and their families: (http://www.afcrossroads.com/famseparation/pdf/ReadinessFamily.pdf)

A triservice program, the Robert E. Mitchell Center for Prisoner of War Studies (http://www.med.navy.mil/sites/nmotc/rpow/Pages/default.aspx), Pensacola, Florida, provides follow-up studies of repatriated POWs of all eras, documenting captivity-related physical and mental problems within the context of extensive annual evaluations. The Center also trains medical personnel of all Services assigned
to operational billets who might be involved in repatriation.

At the highest level, the Defense Prisoner of War/Missing Personnel Office (DPMO, http://www.dtic.mil/dpmo/) searches for MIAs from past conflicts, and also oversees efforts to account for and recover personnel who have become separated from their units during more recent actions. This includes the rescue, recovery, and reintegration of captured or missing personnel through diplomatic and military means.

APPLYING WHAT WE HAVE LEARNED

DoD continues to incorporate lessons learned into future capabilities, ensuring that personnel are properly trained and accounted for. This includes the increasing numbers of DoD contractors and civilians who accompany the military force. In the absence of future scenarios in which large numbers of Americans are taken captive, efforts have accordingly shifted from personnel recovery and the repatriation process to preparing service members, contractors, and civilians to avoid capture. Training also focuses on proper responses if they are captured. Lessons learned through research and operations such as at the Mitchell Center are used in SERE (survival, evasion, resistance, and escape) training. Improvements in technology, planning, training, and command and control have all combined to form a rapid, organized response to isolating events.

In the words of the recent head of the Mitchell Center, Robert E. Hain, CAPT, MC, USN (Ret),

A question that is on our collective minds deals with the fact that so many of our people went through a truly terrible experience but emerged at the other end a better, stronger person. Answers to this question of why ultimately helps us contribute to the body of knowledge that prepares present day fighters to be deployed to a war zone. (Booher, 2012, p. 20)

References


