

# ACHILLES IN VIETNAM

Combat Trauma  
and the Undoing of Character

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## The Breaking Points of Moral Existence—What Breaks?

When a soldier is broken by combat, what breaks? The reader has already had many glimpses of the post-traumatic existence of combat soldiers. It is now time for a more extensive and systematic discussion of combat PTSD. Here is Shakespeare's account of what seems very much like the symptoms of PTSD; the person speaking is a combat veteran's wife:<sup>1</sup>

O, my good lord, why are you thus alone?

Social withdrawal and isolation

For what offense have I this fortnight been

Random, unwarranted rage at family, sexual dysfunction, no capacity for intimacy

A banish'd woman from my Harry's bed?

Tell me, sweet lord, what is 't that takes from thee  
Thy stomach, pleasure

Somatic disturbances, loss of ability to experience pleasure

and thy golden sleep?

Insomnia

Why dost thou bend thine eyes upon the earth,

Depression

And start so often when thou sit'st alone?

Hyperactive startle reaction

Why hast thou lost the fresh blood in thy cheeks,

Peripheral vasoconstriction, autonomic hyperactivity

And given my treasures and my rights of thee  
To thick-eyed musing and cursed melancholy?

Sense of the dead being more real than the living, depression

In thy faint slumbers I by thee have watch'd,

Fragmented, vigilant sleep

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And heard thee murmur tales of iron wars,  
Speak terms of manage to thy bounding steed,  
Cry "Courage! to the field!" And thou hast talk'd  
Of sallies and retires, of trenches, tents,  
Of palisades, frontiers, parapets,  
Of prisoner's ransom, and of soldiers slain,  
And all the currents of a heady fight.  
Thy spirit within thee hath been so at war  
And thus hath so bestir'd thee in thy sleep,

That beads of sweat have stood upon thy brow,  
Like bubbles in a late-disturbed stream;

Traumatic dreams, reliving episodes of combat fragmented sleep

Night sweats, autonomic hyperactivity

## THE OFFICIAL DIAGNOSTIC CRITERIA FOR PTSD OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Of the five official criteria that make the diagnosis of PTSD, all but the first (criterion A, which I shall discuss below) are straightforward clinical description, broadly stated to apply to all PTSD, not only to combat PTSD. I believe at this point the reader will be interested in seeing them exactly as they stand in the official diagnostic manual (known as the DSM-III-R). The dry criteria may come to life if the reader tests them against Shakespeare's portrait and decides whether Harry Hotspur, the most formidable fighter among the rebels against King Henry IV, has it:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

- (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
- (2) recurrent distressing dreams of the event
- (3) sudden acting or feeling as if the traumatic event were

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recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)

(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- (1) efforts to avoid thoughts or feelings associated with the trauma
- (2) efforts to avoid activities or situations that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
- (4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect, e.g., unable to have loving feelings
- (7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response
- (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.<sup>2</sup>

Criterion A is not at all as straightforward as the others. The linchpin of this diagnostic standard is its implicit claim to ethical and culturally neutral knowledge of "usual experience."

In the twentieth century, combatant deaths in all wars worldwide have averaged 180 per million population per year. This

makes war casualties, and their witnessing, sound very rare, less than two in 10,000 (0.02 percent). But life happens in particular not as a worldwide century average. Four hundred died or were seriously wounded for every 10,000 who served in the U.S. armed forces during the Vietnam era, whether or not they went to Vietnam; 1,200 (12 percent) died or were seriously wounded for every 10,000 who served in Vietnam.<sup>3</sup> The percentage of combat veterans, as defined here, who died or were wounded cannot be determined from the available data, but it is surely higher than the 12 percent for all high- and low-combat-exposure servicemen lumped together. Findings from the *National Vietnam Veterans Readjustment Study (NVVRS)*, a rigorously designed and executed nationwide epidemiological study of a random sample of Vietnam-era veterans and a random sample of demographically similar civilian controls, showed that 35.8 percent of male Vietnam combat veterans met the full American Psychiatric Association diagnostic criteria for PTSD at the time of the study in the late 1980s. This many men had grossly unhealed psychological injuries—almost twenty years after their war experience. This is a thirty-two-fold increase in the prevalence of PTSD compared to the random sample of demographically similar civilians. More than 70 percent of combat veterans had experienced at least one of the cardinal symptoms (“partial PTSD”) at some time in their lives, even if they did not receive the full syndrome diagnosis.<sup>4</sup>

Given the luck of assignment to a combat unit, it is *not* “outside the range of usual human experience” to undergo “serious threat to one’s own life or physical integrity; serious threat or harm to . . . close . . . friends; . . . or seeing another person who has recently been, or is being, seriously injured or killed. . . .” This is the *normal* experience of a combat soldier. “Outside the range of usual human experience” pretends that the “usual” deployments of social power have nothing to do with events that cause psychological injury.<sup>5</sup>

The official definition almost totally fails to convey the ease with which PTSD can be confused with other mental disorders. For example, the numbness, mistrust, hallucinated voices of the dead, and social withdrawal of combat PTSD are easily confused with schizophrenia. Some combat veterans remain in an emotionally deadened, socially withdrawn state for prolonged periods and many have been misdiagnosed as schizophrenic. Another

common misdiagnosis is bipolar affective disorder; the current term for what the general public knows as manic-depressive illness. When intrusive relived experiences predominate and the veteran is flooded with emotions of fear and rage, he may stay awake for many days at a time and engage in driven, frantic activity. He may meet the descriptive criteria for mania and have a history of depression and despair—like Shakespeare’s Harry Hotspur—and *voilà*, the diagnosis of bipolar affective disorder is made. A cycle of alternating states of numbness and intrusive reexperiencing is common enough in PTSD for most authorities in the field to regard it as intrinsic to the disorder. Combat veterans in our program who first made contact with the mental health system in the early 1970s were almost universally diagnosed as paranoid schizophrenic, if first seen in the late 1970s as manic-depressive or schizo-affective, and if first seen in the mid-1980s as suffering from PTSD. PTSD can unfortunately mimic virtually any condition in psychiatry.

### PTSD AND THE RUINS OF CHARACTER

Regardless of when they were first seen, most of my patients have also been diagnosed with borderline or antisocial personality disorder, as well as other personality disorders. I do not believe the official PTSD criteria capture the devastation of mental life after severe combat trauma, because they neglect the damaging personality changes that frequently follow prolonged, severe trauma. The World Health Organization’s *Classification of Mental and Behavioral Disorders* offers the category “Enduring personality change after catastrophic experience,” defined as these personality features that did not exist before the trauma:

- (a) a hostile or mistrustful attitude toward the world;
- (b) social withdrawal;
- (c) feelings of emptiness or hopelessness;
- (d) a chronic feeling of being “on the edge,” as if constantly threatened;
- (e) estrangement.<sup>6</sup>

More than simply inflicting the set of symptoms described in DSM-III-R, prolonged combat can wreck the personality.<sup>7</sup>

