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Independent and Peaceful Australia Network

People's Enquiry: Exploring the Costs and Consequences of the Australia-US Alliance

Comments on: The Mental Consequences of Military Service

1. I submit that I am qualified to give an opinion on the mental consequences of military service, including periods of combat. My CV and publications list are available if required. By way of background, when I first had regular professional contact with military veterans, at RGH Hollywood, in Perth, in 1977 (my final year of postgraduate training in psychiatry), the great majority of patients were World War II veterans aged in the sixties or older, as well as a sprinkling of veterans of Korea and increasing numbers of Vietnam veterans. I also saw several veterans of World War I but I had known quite a number of them where I grew up in Albany, WA. For the record, I spent five terms of my schooling at the Princess Royal Forts in Albany, now site of the National ANZAC Memorial.
My practice in psychiatry was unusual in that it was oriented toward young men. This stands in contrast with normal urban private psychiatric practice in which patients are much more likely to be female and middle-aged to elderly. As much as anything, this was a product of where I was working, not a deliberate choice. It had the benefit of providing me with a steady stream of civilians of much the same age and background as the serving personnel and veterans whom I was seeing, so comparisons were easy.

2. In 1977, mainstream psychiatry was still using the diagnostic categories and treatment schedules developed in the late 1940s and early 1950s. At the time, there was no category of mental disorder relating to the effects of major psychological trauma. The orthodox view was that any person who developed severe or long-lasting psychological symptoms following adverse life experiences was simply showing a preordained condition or weakness revealed by the stress of service. However, this view was changing as published studies showed how people's lives were dramatically affected for the worse following incidents such as the Cocoanut Grove fire in Boston, 1942, in which nearly 500 people died; the Buffalo Creek mining disaster (New York state, 1972); long-term studies of survivors of the Nazi concentration camps; the loss of HMAS Voyager in 1964, and many others.
The essential point that swung psychiatric opinion away from the pejorative concepts of "lack of moral fibre" (LMF, an actual diagnosis), "weak character" or "hereditary diathesis" was that men with exemplary records suddenly changed even when they were not present at the time of the incident. For example, in Buffalo Creek, miners who were underground at sites removed from the town when the dams burst, and who lost their homes and families, suffered the same symptoms in the same proportions, intensity and duration as relief workers and those injured during the disaster.
Following the defeat of the US-led alliance in Vietnam, it became unavoidable that huge numbers of veterans were suffering a consistent pattern of mental disturbance just as a result of their military experiences. This was formalised in 1980 when the (misleadingly named) category of Post-Traumatic Stress Disorder (PTSD) was included in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III).
Since then, and despite very extensive research directed at finding a physical cause in the brain for the class of acquired and post-traumatic mental disorders, no consistent or even interesting findings have emerged to suggest that this is anything other than a purely psychological condition. However, because modern psychiatry is overwhelmingly biological in orientation, treatment is very largely based in medical concepts of drugs, hospitals, electroconvulsive treatment (ECT) and other forms of

brain stimulation (actual brain surgery is no longer considered an option). Psychological management tends to be of lesser importance and is largely based in dated behaviorist techniques, such as relaxation training and "anger management," and some, such as eye movement desensitisation and reprocessing (EMDR), whose model was developed *post hoc*.
In the main, it would be fair to say that, for the sufferers, management of post-traumatic mental disorders is far from satisfactory. For the practitioners, it is highly lucrative with very little risk that the patients will actually recover and return to *status quo ante bellum*. In the US, for example, with its enormous veteran population, there is good reason to believe that part of the vast sums of money spent on treatment would be better spent on housing, recreation and other social forms of management, but their Veterans' Health Administration is heavily medicalised. In turn, the psychiatric profession is heavily influenced by drug companies, so such changes are most unlikely to happen.
Arguments over the nature of post-traumatic mental disorders and the proper form of management will continue to flow back and forth, just because mainstream psychiatry has no standard model of mental disorder that dictates treatment. It is widely bruited that mental disorder is fundamentally biological in nature but this is an ideological claim, with no basis in established theory [1]. In short, psychiatry is the only medical specialty that does not have a model of its field of study, meaning it is, at best, prescientific in its level of development [2]. As always, the patients bear the brunt of this shortcoming.

3. With this caveat, I wish to comment on a matter that is of profound importance to the sufferers themselves but receives remarkably little attention from psychiatry. Most attention is directed at the terrible problem of veteran suicide but there is another matter which contributes to this toll, the impact of post-traumatic mental disorders on male sexual function. Most studies of uninjured combat veterans report rates of major sexual dysfunction of about 20%, which is already much higher than among their civilian peers. However, among veterans receiving benefits for PTSD, the rate of sexual dysfunction is about 85%. This is severe, largely resistant to treatment and essentially permanent. It causes severe distress to the individual and can have a devastating effect on established relationships, as well as strongly inhibiting attempts at new relationships.
In the early 1980s, while chief psychiatrist at RGH Hollywood, I had the job of reviewing men who had applied for surgical treatment of sexual failure dating back nearly forty years. They were then in their early sixties and were deeply humiliated by having to talk about it. Before surgery, they had all tried intrapenile injections with no improvement. The surgery itself was gross and only the absolutely desperate would contemplate it, particularly as it also failed in the majority of cases. Fortunately, both of these were soon superseded by drugs such as sildenafil (*Viagra*). At the time, we knew almost nothing about sexual dysfunction among female veterans and we still don't know a lot more.

4. While psychiatry generally has quite a lot to say on the mental tribulations of post-combat veterans, there is also a large group of men medically discharged from the ADF following training and other non-combat injuries, particularly back, knee and shoulder damage. These are often severe and can lead to total and permanent incapacity benefits but the incidence of major mental disorder among these veterans is also inordinately high. Strictly speaking, their rates of mental disorder should be no higher than among civilians who have sustained similar injuries. However, the sense of loss among veterans after medical discharge is much higher than among civilians, and is likely to very long-lasting. For the majority of veterans discharged as unfit, nothing can replace the exhilaration of military life, and protracted states of reactive depression are very common, probably universal in the first few years. Again, the incidence of treatment-resistant sexual dysfunction is high, as are the levels of distress directly resulting from the disorder. It should be understood that

mental disorder, treatment and sexual dysfunction are closely interwoven and, to a large extent, self-reinforcing.
The great majority of recruits to voluntary military forces, especially in Australia, are self-selected, with minimal pressure for financial or other reasons. They are generally fit and strongly oriented toward a physical lifestyle. Given the choice of a day playing computer games or a day's scuba diving or motorcycling, there would hardly be any who would choose the former. Consequently, the loss of the outdoor, physical and very social lifestyle offered by the military impacts them far more than most injured young people. The depressive reaction to loss of lifestyle is wholly psychological in origin and barely responds, if at all, to conventional psychiatric treatment of drugs, etc. However, all psychiatric drugs have powerful inhibitory side effects on sexual function. In men, they produce a loss of libido (sense of interest and drive for sexual activity) varying from mild to profound; partial or complete impotence (inability to initiate or maintain erection); loss of somatic and orgasmic sensation (anorgasmia); and ejaculatory failure. Compounding this, men are humiliated by their failure, which produces further anxiety when contemplating sexual activity. This causes further social withdrawal, loneliness and depression, often leading to alcohol or drug abuse, thereby intensifying the sexual dysfunction. Treatment with PDE5 drugs such as sildenafil is only partially successful at best.

5. It is fair to say that, at least among men, sexuality is an immensely important part of the personal identity, as well as a major source of satisfaction and, through children, meaning in life. It is also fair to say that sexual dysfunction among military veterans is common, and not just among those discharged due to injuries. However, among the latter group, the incidence is far higher, to the extent that an injured veteran with normal sexual function would be unusual. This adds a layer of disability and dissatisfaction with life that, due to the humiliation it produces, is largely invisible but it is nonetheless a very real thing that adds greatly to the level of suffering in the long term.

6. Voluntary military forces rely on a steady stream of recruits eager to show they can meet the standard. Many apply as soon as they are old enough, meaning eighteen, while most would have done so by age twenty. For years, I commented on the generally poor standards of psychological assessment of applicants but that is a separate issue. For the present, I focus on the concept of "informed consent," meaning that people who are signing a form of contract need to be told in some detail the consequences of their signature. We are no longer talking about conscription, when recruits were told in no uncertain terms that they had to take it as it came. These days, applicants are better educated and have a choice.
Advertising for ADF mainly consists of unnaturally healthy and happy people sitting in a helicopter, bounding heavily-armed through the bush or piloting a speedboat through sapphire seas. The ADFR website, Defencejobs, has a video background in which ships, helicopters and tanks are prominent. A menu item, "Lifestyle and benefits," says:

> In the ADF you'll enjoy a rich and rewarding blend of career and lifestyle opportunities, plus fulfilling, well-paid work, job security and numerous benefits.

Subheadings include "excellent salary packages, unique experiences, job satisfaction, work-life balance, lifelong friendships, training and development." The clear impression given is "Join us for a life of fun, travel and adventure." Nowhere could I find a link to "risks." Cigarette packets carry warnings of risks, but not the military.

7. Conclusion: A choice made with false or misleading information is not a choice. Applicants are not told "If you enlist, you have a much higher risk of being seriously injured than if you remain a

civilian. If that happens, you are likely to be discharged medically unfit but the risk of more or less permanent loss of sexual function is high to very high. That can happen as young as twenty."

Granted eighteen year olds are not the most forward-looking members of the community and generally bathe in an enviable sense of invincibility, but even they need to know the risks. Bearing in mind that the whole of Australia's military activity since 1945 has been a complete waste of people and resources in the service of another country's imperial/messianic ambitions, the damage done to our young people, in return for no discernible benefit to them or the nation, needs the widest publicity.

I once told a group of senior ADF officers that sexual dysfunction was a problem that needed to be addressed (needless to say that, as senior officers, they had never experienced significant injuries, physical or mental, and generally hewed to the notion that real men don't get sick or injured but if they are, they would never complain). They seemed surprised to hear of it and I suspect they didn't actually believe me. When it was suggested that the ADF needed to tell applicants of the exact risk of major loss of sexual function (which DVA can easily determine), they were aghast: "But if we did that," they exclaimed, "nobody would enlist."

Precisely.

References:

1. McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychology and Psychiatry* 15: 7-18.

2. McLaren N (2020). The Biopsychosocial Model: the end of a reign of error. *Ethical Human Psychology and Psychiatry.* 22:71-82.