



Interview with Professor Frederick M. “Skip” Burkle, Jr.

By Erin Smith with Frederick M. Burkle, Jr.

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Frederick M. “Skip” Burkle, Jr. is an American physician known for his work in disaster response and humanitarian assistance, public health preparedness, human rights, international diplomacy and peacekeeping.

The Washington Post called Professor Burkle "the single most talented and experienced post-conflict health specialist working for the United States government." His medical qualifications include pediatrics, emergency medicine, psychiatry, public health, and tropical medicine.

Drafted into the United States Navy during the Vietnam War, he served as a military physician with the Marines and completed combat tours in the Vietnam War (1968), the Persian Gulf War (1991) and Somalia (1992) with the 1st, 2nd and 3rd Marine Divisions, and with the United States Central Command in Somalia. He also served with the Red Cross in the Kurdish Refugee Crisis and as a negotiator for the Kurds in Baghdad. In 2002, Professor Burkle received a White House Appointment to serve as Deputy Assistant Administrator for the Bureau of Global Health at United States Agency for International Development (USAID),

United States Department of State. In this capacity, he was appointed the first Interim Minister of Health in Iraq in 2003 during the planning and immediate crisis period.

In January 2017, WADEM (World Association for Disaster and Emergency Medicine) named its biennial Award for Global Leadership in Emergency Public Health in honor of Skip, recognizing his outstanding contributions to the science and practice of humanitarian relief efforts.

In this edition of the WADEM Psychosocial Special Interest Group's Newsletter, Professor Burkle shares some of his thoughts on the psychosocial impact of war and conflict with the Co-Convener of the SIG, Dr. Erin Smith.

E: Skip, thank you so much for taking the time to share some of your thoughts and experiences on the psychological impact of conflict with the members of WADEM's Psychosocial Special Interest Group.

S: Erin, I'm honoured by your request. I want to say upfront that as a student of war-related psychological problems since the Vietnam War I have found the subject perplexing and unlike any other that we face in healthcare today. The interested audience, by and large, has been small and mostly limited to military psychiatrists and psychologists. Major operational and educational decisions have been made without benefit of good research or been overturned primarily through post-conflict evaluation research. Currently nothing has been more complex, and contentious, than the debate over the existence of and the impact of war on the development of PTSD. You will see that problems defining the nature of and response to psychological events witnessed in both the military and civilian war-related populations, while substantial, have not necessarily led to consensus in cause or response.

It remains an open book.

The subject is important enough to recommend that WADEM's Psychosocial Special Interest Group consider it a priority issue suitable for further study that might lead to educational and operational recommendations and competencies, especially as the WADEM membership become more involved in mental health decisions impacting war, armed conflicts and refugee populations. I have included at the end of my comments a listing of references I have found useful over the years and I speak to in the questions asked.

It is probably best to first explain how this topic led to occupy my mind for decades.

Honestly, Psychiatry was my least favorite subject in medical school, as I was singularly driven by a dream to be a paediatric surgeon practicing "global health" in rural Africa and Asia. My first Residency was in Paediatrics at the Yale University Medical Center, which in those days was required before one was accepted into the paediatric surgical training program. However, 3 years later when I completed this training I was drafted into the military. Within 20 days I found myself in Vietnam in a Marine Forward Casualty Receiving Facility (FCRF) a few miles south of the DMZ in 1968, an area of the country where most of the battles of that war took place. The area was unique in that the negotiate division of the

country in 1952 established the 32 mile long DMZ which led to over 30,000 refugees fleeing from North Vietnam. They found themselves equally shunned by the regime in the South and were forced for decades to settle along the DMZ in unstructured refugee conclaves. Our triage-bunker casualties were often a mixture of Marines, Viet Cong, North and South Vietnamese soldiers, and civilians. No matter how well you think you have been trained every war becomes a daily learning experience.

As physicians we were all draftees except for the Commanding Officer. We knew little of the military culture and demands, and none of us had mental health expertise, which was first available at the next highest echelon of care. Despite the many demands for trauma triage and immediate casualty care it soon became obvious that war-related “psycho-social” problems were as pervasive as the trauma. Our lack of knowledge was tainted by our own ignorance, a language and culture we did not begin to understand, the mixed attitudes of the military over how to manage psychological casualties, and our own prejudices and unfamiliarity on how to diagnose and manage such challenges.

The trauma facility was frequently hit by artillery from north of the DMZ and was often coordinated by the NVA to hit just minutes after the helicopter arrival of casualties. Months later we became a dual functioned children’s hospital and trauma facility that opened our eyes to the unattended suffering of children. These challenges included multiple infectious diseases, the largest bubonic plague epidemic of the last century, scurvy, severe malnutrition and multiple weaponry related injuries. The massive civilian needs rapidly became evident to the otherwise unprepared military corpsmen and physicians alike and with success only resulted in more frequent threats from the Viet Cong and NVA who competed with us for the “hearts and minds” of the war weary civilian population.

In 1973 during a Grand Rounds presentation at the Uniformed Services University of Health Sciences in Bethesda, I discussed coping with stress in conflicts. I admitted that five of the 18 physicians with whom I worked in Viet Nam developed brief but debilitating emotional consequences. Two suffered from first-time acute asthmatic attacks with marked emotional overlay, one suffered catatonia on arrival of our own casualties, and one developed hyperactivity, depression, and transient psychosis. In this case sleep deprivation, alcohol consumption, and threats to his life from parents of children who died during emergency surgery possibly contributed to the development of symptoms. An additional physician developed a psychosis on returning home. Psychosomatic symptoms were common, especially where verbalization of anger and other feelings was not commonly perceived as being an acceptable outlet for a military officer. Literature from the Yom Kippur War describes differences in psychological reactions between members of elite combat units where there was considerable social support and reserve units and incoming draftees where members were total strangers to each other.

It was during the Vietnam War when I began to appreciate and plan for the population focused competencies I needed for my own future global health skill sets that I would encounter in wars, armed conflicts and refugee care in the decades that followed. I became qualified in adult and paediatric emergency medicine, paediatrics, completed my public health degree at UC Berkeley where I focused on population-based mental health, a

psychiatry residency at Dartmouth, Fellowship in Adolescent Medicine & Psychiatry at Harvard, and diploma in tropical medicine. Today, reliable competency-based courses are readily available to an ever expanding and eager humanitarian audience. While I ended up doing all that any psychiatrist would be obliged to do in the individual treatment and therapy of patients, my interest and education was increasingly focused on population-based care and the challenge of how those individual-based care skills I learned could be translated to a suffering population such as refugees and other vulnerable populations of civilians. Since, I've been called back for 5 wars and multiple armed humanitarian crises on every continent I have used all these skills and acquired many more as the reasons for war and conflict and how the world responds to them changed dramatically every 10-15 years or sooner.

E: During World War One, soldiers exhibiting psychosomatic symptoms were given the label "shell shock." The cause of their invalidity and, therefore, the appropriate form of management was the subject of considerable debate. Are shell shock and PTSD the same disorder by a different name?

S: First, I must emphasize that with every war, starting with WWI, the military leadership has always displayed strong ambivalence toward psychiatrists, psychologists and other mental health workers in the military affairs of war. Unfortunately there will always be a component of the military who will label psychological victims as "cowards, malingers, or lacking in moral fiber." In WWI, they were not prepared for the large numbers of victims who, to them, posed serious concerns over maintaining the manpower needed to win battles. This was especially visible when publicity emphasized that the force was the "best trained and prepared warriors" that any country could produce.

The ignorance and unpreparedness for caring for both the military and civilian population's psychosocial needs during war and conflict have remained a pervasive denial-driven subject that, quite honestly, has changed little since WWI. What these casualties are labelled as and how they are managed will always be "medicalized" and "politicalized" in favour of one objective and operational priority, that of keeping the force "intact, eager and convinced of their invincibility."

Shell shock was first coined to describe the physical reaction of over 80,000 cases that arose from the intensity of the bombardment that produced total helplessness when a soldier was unable to function and no other physical cause could be identified." First evaluated by military physicians, it was seen as neurological in nature related to the direct effect of exploding shells. It was from Charles Myers and other civilian psychiatrists who convinced the British military to accept that shell shock was a "psychological reaction" to the "stresses of warfare rather than the expression of a predisposition to mental illness." They introduced "psychotherapeutic interventions" for the first time, eventually incorporating into military operational thinking the deployment of psychiatrists placed "as near the front line as military exigency will permit." While the acceptance of a psychological component was the earliest introduction of what PTSD would eventually become, researchers today feel "it bore little overt resemblance to the modern diagnosis of PTSD that includes psychological symptoms and signs."

E: During World War Two, “breakdown” on the battlefield became a priority for the Allied democracies concerned that high casualties would undermine popular support for the conflict. Military psychiatry became an essential element of medical provision. With the direct involvement of the United States and its wealth of resources, attention was turned to evaluating the nature of breakdown and the effectiveness of treatments. What did we learn during this time?

S: Getting the soldier back to the front as quickly as possible remained the WWII priority in order to maintain operational efficiency. An emphasis was put on screening potential recruits before acceptance into the military. This proved unsuccessful, was eventually abolished and many of those initially rejected were then drafted. Unfortunately, initially in WWII and the Korean War military physicians continued to “medicalize” the signs and symptoms despite the fact that they were identical to those seen in WWI. For example, those with combat related psychoses were frequently evacuated with the diagnosis of “acute schizophrenia.” To the chagrin of the physicians, their reintegration and complete resolution of their psychotic behaviours resolved when they were taken out of combat yet their records often continued to show the diagnostic label of “schizophrenia.” Eventually, progress was made in “shifting attention from problems of the abnormal mind in normal times to problems of the normal mind in abnormal times” Yes, war is hell, or worse, but few wished to admit it!

The “forward psychiatry” component of WWI was continued and claimed to return up to 80% of “neuropsychiatric cases” to duty within a week. However, with post-WWII research these figures were adjusted downward to “very low.” Successes seen were probably best attributed to availability of extensive and well-equipped psychiatric services and the now committed belief that “all service personnel are potential stress casualties.” Unaware of similar initiatives in WWI, the WWII and Korean War “introduction of simple and straightforward treatments of rest, good food, hot showers, and sedation” were again claimed to be successful in returning men to the front line in a matter of days.” What appeared to matter the most was an increasing acceptance that they “were not cowards nor weaklings...but rather normal individuals who could no longer cope with the unremitting and horrendous stresses of war.”

E: Today, the recognition of post-traumatic stress disorder (PTSD) has established in the minds of the public, media and health professionals that conflict can produce long-term and severe psychological effects. However, is it the case that this was not always so?

S: The current view emerged, for the most part, from information that claimed that psychological effects were short-term, possibly influenced because time long-term studies on veterans were rare. Some components of PTSD, as we define it today, were certainly recognized in prior wars and conflict but under different names...that is one of the problems we’ve brought on for ourselves that has contributed to the confusion. Make one thing clear, PTSD is not unique to today’s wars and conflicts. Before the Vietnam War consensus among therapists was that soldiers “who recovered from an episode of mental breakdown during combat would not suffer adverse long-term consequences...that disability commencing after the war was believed to be related to preexisting conditions.” PTSD during and after Viet

Nam deemphasized the role of the original traumatic event in the development of symptoms, “by highlighting the importance of a variety of contextual factors, among them the perception of social support, preexisting anxiety or depression, and a family history of anxiety.” Additionally, both during and after the Vietnam war extensive and well-equipped mental health services became more available, visible and acceptable...but their impact has never been adequately researched.

E: The political crisis created by the Vietnam War, combined with significant cultural change, inspired a new interpretation of trauma psychiatry. Can you comment on this?

S: Fifteen years after the Vietnam War, epidemiological studies concluded that 15% of Americans who served were suffering from PTSD and now appeared as a diagnostic category in the 1980 Diagnostic and Statistical Manual of the American Psychiatric Association. Furthermore, the varied incidence of PTSD that ranged from 3.5% to 50% among Vietnam veterans resulted in hotly debated discussions that continue today. Unfortunately, PTSD among veterans of the Persian Gulf and Iraq Wars that range from 15.6 to 17.1% renewed debate once again over “weakness of character or cowardice” as factors. Essentially the Gulf War has shown little attention to PTSD.

Pols and Oak suggest that since the Vietnam War long-term psychiatric disability best reflects individual factors that predated the war, such as familial predisposition for mental illness. Others claim that “no specific set of medical symptoms can be identified after each war, and because each war has given rise to an increase in unexplained medical symptoms it is argued that investigating the exact nature of postwar syndromes will not yield constructive results”, a factor that has led to recommendations for integration of psychiatric approaches into primary health care settings for these veterans as well as for civilian migrants and refugees who were also caught up in current prolonged conflicts.

This being said, research on PTSD following deployment to Iraq and Afghanistan was reviewed in 2014. While the studies found a large variability in the prevalence rate, the PTSD rate was higher among Iraq-deployed compared to Afghan deployed and higher in combat deployed (Canadian, US, UK army or the navy/marines) compared to other services...but no difference was seen between active-duty or reserve/national guard. Interestingly, higher rates occurred in those with combat exposure and life and family disorders during deployment. Curiously, more post-conflict PTSD research seems to be originating from the UK and Canada than the US.

E: Women, children, the elderly and the disabled living in conflict-affected areas are particularly vulnerable to mental health problems. However, the traumatizing impact of direct exposure to violence and conflict can particularly compromise the psychological wellbeing of adolescents. What makes adolescents vulnerable?

S: As an adolescent psychiatrist, I would say that the impact of violence and deaths from war varies depending on exposure, effects on their parents, survival needs, their understanding of the conflict, direct threats of violence and whether they themselves engage in harming others. Yet, all adolescents have the potential to suffer greater capacity for hopelessness,

despair, disillusionment, aggression and antisocial behavior, risky and reckless behavior, disturbing images, depression and permanent learning problems.

Adolescence is the time in life when we first experience abstract reasoning and with it enhanced ability to both question, comprehend and deal with personal experiences and uncertainties such as guilt, anxiety, and shame in their actions as one's conscience is formed. We can feel many insecurities, false omnipotence and despair and depression for the first time. Unfortunately, in current conflicts it is not at all uncommon to find increased use of adolescent-child soldiers and sexual abuse and exploitation of adolescent girls. Historically, warring has been used as a 'right of passage' into adulthood. In crises, we have had reports of some young adolescents returning to more childlike behaviors in need for security while others have brazenly wanted to identify with adults and serve in that capacity during war and major natural crises. We briefly provided security for a Marine who was found to be only 16 years old and was awaiting return home. Gravely, he was killed in our compound while cleaning his weapon. We were never able to establish whether it was a suicide or an accident.

Militarily, Vietnam was very much a young person's war with 61 % of deaths under the age of 21. Twenty-six % of the Marine casualties, or 20,574 were between ages 17-19. Of all services there were 11,398 deaths of those aged 17-19 years among 58,220 total deaths of which 16,899 (the highest number of any year) occurred in 1968 alone, the year I served. The Marines were highly disciplined and characteristically, compared with other services, would silently lie on the stretcher "at attention" without a whimper despite terrible wounds. Yet, that façade was thin. One particularly crowded day of casualties in Triage a young Marine began to softly call out "Mother"...only to be followed by most of the wounded Marines crying out the same name in unison. We worked in silence saying little but muted orders back and forth to corpsmen all of us dripping tears. We said nothing of that day.

E: What have more recent conflicts and complex humanitarian crises taught us about the psychosocial consequences of war, internal conflict and disrupting living conditions?

S: Those among displaced populations escaping from conflict, whether locally displaced, refugees or migrants, in need of psychosocial and mental health support represent several overlapping subpopulations of people with: (1) Disabling biological psychiatric illnesses; (2) severe psychological reactions to trauma, and (3) those individuals with significant problems who may be able to cope and adapt once peace and order are restored ...this latter group generally represents the majority of the population and clearly supports the decision not to jump to labeling anyone with a clinical "diagnosis."

You don't generally hear much about displaced populations from the established mental health community because "mental health" care as we know it in society today and in the manner in which we are professionally trained as psychiatrists, psychologists and mental health workers is primarily focused on the individual patient who is more often viewed, evaluated and treated within the framework of a medically treated "biological illness." In refugee camps we often see new foreign mental health aid workers gravitating toward those refugees who appear most "mentally ill"...and indeed may be greatly rewarded by

successfully restarting them on their medication for bipolar disease, schizophrenia, severe biological depression that have been absent since their fleeing. But honestly, these “medical patients” make up a very small but highly visible percentage of those needing your attention and expertise; such as those threatening suicide or violence who may be found roaming and frightening others in the newly built refugee camp. Successful management of these problems by aid workers often lessens the fear of the refugee population and has the potential of resulting in other new refugees trusting the foreign aid workers in revealing their own problems...which in the long term will require most of your attention and time. If successful you have practiced “population –based psychiatry and psychology “ that I talked about decades ago in Viet Nam!

Culturally, there are rarely many indigenous mental health workers; those duties are usually relegated to local nurses or family members. Psychiatrists and psychologists are rare. I have seen foreign aid workers arriving with stuffed pockets of psychiatric medications handing them out to local nurses. This is not good practice as the nurses are only familiar with psychiatric medications that are on the national formulary which vary greatly by country. The medications may be those last used in the West during the 1960s and 70s. Rather than bringing in new medications that cannot be found on the formularies of indigenous countries or be replaced, and which may have multiple side effects unfamiliar to the local health providers, it is imperative that humanitarian workers know the WHO guidelines for country-specific psychotropic medications in the Interagency Emergency Health Kit before deployment. If you can re-establish some sense of safety and spend time and patience supporting the local nurses in recovery then you have accomplished much.

E: Do you think that the short-term interest in mental health following conflict can be effectively used to promote longer-term mental health system reform?

S: Yes, definitely...but only if aid workers understand the culture and follow up with the UN, humanitarian and non-governmental organizations who work in these countries long term and desire both input and long term commitments to care. Changes are possible. We have seen improvements but the process is often disappointingly slow. Nationally and internationally we put resources into the “response” phase only. Mental health programs are only successful if they become part of preparedness, prevention, recovery and rehabilitation phases of the disaster cycle. In developed countries mental health programs are considered part of “essential public health infrastructure and protections” along with maternal and child health and vaccination programs. In the countries in conflict the described “essential infrastructure and protections” either never existed or were destroyed.

What is telling is this quote from Jan Egeland, the former UN Emergency Relief Coordinator who in 2004 stated, *“I often have to talk about “forgotten emergencies” and my responsibility is to alert the world to the emergencies it chooses to neglect. But the mental health crisis is not just neglected; it is also very much a hidden emergency. What we must do is bring it out of the shadows.”*

Lastly, I recently wrote that the nature of war has changed, not for the better. I must predict that psychological issues, especially among civilians will escalate. The combination of

marked diversity of conflicts, the numerous parties in conflict, prolonged urban warfare, denial of applicability, political will and politicalization of protections under international humanitarian law (IHL) has increased since 2003. This has resulted in unprecedented “disproportionate attacks” or so called “Violations of Proportionality.” These cause under the IHL “incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated.” The total destruction by the Syrian government of east Aleppo and Western-based bombing campaigns that flattened Raqqa have been condemned by the UN as violations of proportionality risking a collapse of efforts to increase respect for IHL and to regulate the behavior of the parties to conflicts.

E: Skip, thank you so much for taking the time to share some of your thoughts and reflections with our membership. Your insight is, as always, invaluable and much appreciated.

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