COMBAT STRESS AND NEED FOR DEVELOPMENT OF TRAUMA PSYCHIATRIC SERVICES IN PAKISTAN ARMED FORCES

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INTRODUCTION

War is one of the worst man-made disasters, the sequelae of which continue to influence and haunt people not only in their lifetime but also leaving an impact on the generations to come. Destruction of life and property is only one aspect of the war. What happens to millions of those who come back from the war, is an issue, which is often ignored.

The soldiers are driven by their instincts, ambitions, motivations, fears and submission to the cause of war. The concept Combat Stress encompasses these very issues. Stress is viewed as a phenomenon, which afflicts both the victors and the defeated. It addresses the changes that are seen in the soldiers during and after wars. Management of this stress improves combat performance, restores health and rehabilitates the precious soldier.

The western countries have taken the initiative in identifying and managing these issues. The British Army during Word War-I collected the first scientific data [1], but thereafter, World War-II, Korean, Vietnam, Arab-Israel War, Falklands and Gulf wars have provided valuable data on the subject.

The average figure for the Stress-related Casualties during these wars has been reported to be around 40% [2].

Pakistan Army has also experienced at least three wars, multiple low intensity conflicts and a persistent ongoing active deployment. We have not been able to address the issue of Combat Stress in our veterans merely because of our ignorance to the concept. The battleground of Siachin, skirmishes of Kashmir and the special operations on foreign grounds (UN missions) are descriptive of stories related to stress of combat.

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HISTORICAL PERSPECTIVE

The US Army suffered at least 56% stress related casualties which came with diagnoses of "War Neurosis", "Shell Shock", "Gas Mania" and "Not yet diagnosed; Nervous", during the World War-I [2]. The information collected during this experience was used to develop Combat stress Control Program for the Army. World War-II saw a slight decrease in the number of stress casualties. War neurosis was given the name of "Combat Exhaustion". A large number of "Rest Centers", "Exhaustion Centers" and "Training and Rehabilitation Centers" were established at all levels of the formations. Their function was to recognize and treat Battle Fatigue casualties and ensure their early return to duty [3].

The Korean War saw an improvement in the concept and organization of Combat Stress Control. Eighty five percent (85%) of the Battle Fatigue casualties were returned to duty within 3 days, 10% returned to limited duty within 3-4 weeks and only 5% had to be returned to rear hospitals [4].

Vietnam War proved a challenge to the concept of Battle Fatigue. A large number of the conscripted troops were highly educated and professionals. The traditional Battle Fatigue was not seen, rather, issues of substance abuse, breeches of discipline and indulgence in atrocities were the more frequent kinds of behaviors encountered. The aftermath of this war also saw recognition of a new stress related diagnostic entity, namely,

Posttraumatic Stress Disorder, which afflicted a large number of veterans producing lifelong psychiatric handicap. Consequently the stress casualties increased enormously, accounting for 57% of the total casualties [5,6].

CONCEPT OF COMBAT STRESS

The experience of combat provides the soldier to confront death in the closest proximity and this proximity itself brings about long-lasting changes in the individual. The subject of Combat Stress addresses these changes. It can be positive or negative and may appear as physical or mental. It can be acute or long-term in nature. The positive Combat-Stress-Behavior (CSB) improves war performance, produces heroic acts, induces courage, gives exceptional strength and endurance, provides mission sense and improves war worthiness of the troops. Conversely dysfunctional or negative Combat-Stress-Behavior is counterproductive (table).

a. Positive Combat Stress Behaviors:

Combat brings out the best and the worst in human beings. The direction, which a combat stress behavior takes, positive or negative, results from the interaction of the body's reactions and social context in which the stress occurs and the natural stress response of the body (preparing the body for fight or flight). The purpose of good military leadership, discipline, and training is to bring out the best while preventing the worst.

Positive Combat Stress Behaviors include traditional acts and values like vigilance, strength and endurance, sense of confidence and desire for recognition, personal bonding and cohesiveness, sense of purpose, faith in Almighty, espirit de corps and heroism. These acts of bravery and heroism develop through a physiological and psychological process, which is dependent on sound and moral leadership, military training and discipline. However, these very processes can also lead to misconduct behaviors under the effects of stress of combat, thereby implying that it is a "double-edged sword", for which commanders have to be aware of.

b. Dysfunctional Combat Stress Behavior:

These are divided into the following types.

i) Battle Fatigue:

Also known as Combat Fatigue, Combat Stress Reaction and Shell Shock. It refers to a clinical condition, which manifests in the form various physical and mental symptoms. Hyper-alertness, anxiety, shakiness, feelings of inadequacy, grief and simple exhaustion predominate the clinical picture. Psychogenic loss of motor, sensory, speech or memory functions are less common.

Many factors contribute to battle fatigue, for example: nature, intensity and/or duration of combat; insufficient training, cohesion or leadership; home front concerns; physical stress, sleep loss and fatigue. An average rate for heavy conventional combat is 1x battle-fatigue casualty for every 3x wounded in action (World War II data). During or immediately after heavy actions by company-sized units, battle fatigue cases have equaled the wounded casualties. On chemical battlefields, stress casualties among inexperienced troops may temporarily exceed chemical casualties 2:1 (WWI data) [2]. Battle fatigue also occurs in headquarters and combat service support troops who deal with the consequences of modern weapons.

ii) Misconduct Stress Behavior:

These behaviors do not necessarily occur only in combat ineffective soldiers. The "misconduct" may or may not interfere with specific combat tasks, and may even be done by otherwise "excellent" soldiers, but is harmful to discipline and perhaps to the morale or physical health of the individual. It cannot just be treated with reassurance and rest as for Battle Fatigue. Once they occur, they require administrative action, specific

medical or surgical treatment and/or punishment.

For example, malingerers must be counseled and returned to their units. Self-inflicted wounds must be investigated and, if deliberate, also require disciplinary action as well as surgical treatment. Desertion or commission of war crimes and atrocities must be punished, even though we may pity the over-stressed soldier as well as the victims.

Alcohol and drug abuse may be included under the heading of Misconduct Stress Behaviors, but are not necessarily reactions to combat or deployment-stress. Self-medication and misuse of drugs happens usually for relief of anxiety and tension, to which the combat veteran feels entitled. It may also relieve the boredom, frustration and loneliness. It may also be a way to gain rapid admission into a cohesive group. Drug misuse also occurs in good soldiers and even leaders who are trying to improve or sustain military performance with stimulants or anabolic steroids, which can produce serious psychiatric disorders, in addition to compromising their responsibilities and jeopardizing the safety of their troops.

c. Posttraumatic Stress Disorder (PTSD):

Painful war memories and dreams, even long after a war, are normal. These only become a disorder when they interfere with the veteran's happiness and social effectiveness. They may, however, cause many combat experienced soldiers to unnecessarily leave the Army. PTSD is a recognized, treatable disorder, which shares many common features with Battle Fatigue. PTSD can also occur for the first time many years later. PTSD can also be the long-term consequence of observing or participating in Misconduct Stress Behavior (Fig 1).

PTSD is prevented by immediate small-unit post action debriefing and by systematic preparation of individuals, units and their rear detachments and families during redeployment.

iii) Principles and Objectives of Combat Stress Control:

The principles of Combat Stress Control are: -

- Primary prevention:

  By Primary prevention is meant that combat stress is treated before it happens. This is achieved by promoting development of Positive Combat Stress Behaviors and also by preparing and training the soldier for recognizing Battle Fatigue, Misconduct Stress Behavior and Posttraumatic Stress Disorder. This is the responsibility of commanders and leaders of the troops and is a subject in itself. They need to be well conversant in the concept of Combat Stress.

- Secondary prevention:

  Once the combat stress has set in, it needs active and enthusiastic treatment for prompt and effective relief of symptoms and ensuring early return to duty. This is the responsibility of health care professionals, especially, psychiatrists.

- Tertiary prevention:

  It implies reduction of the handicap and chronic disability of soldiers who are irreversibly afflicted with the stress of combat. This aspect requires the services of Rehabilitation Centers and Institutions of Welfare.

  - Treatment of Battle Fatigue:

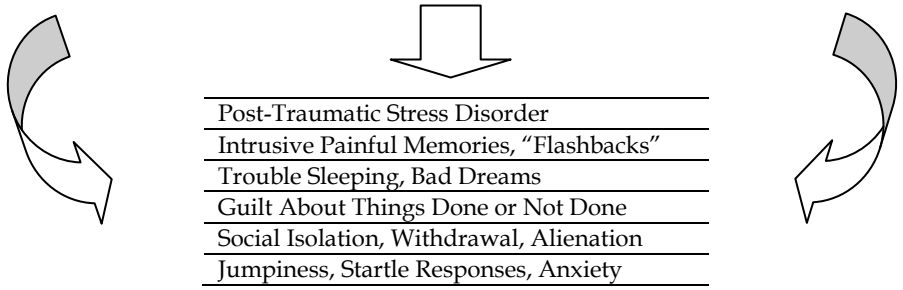
    Using the widely adopted principles of Proximity, Immediacy, Expectancy and Simplicity (PIES), the Battle Fatigue casualties are treated and returned to duty as soon as possible.

  - Management of Misconduct Stress Behavior:

    This area needs strong, just and prompt decisions on the part of

Table-: Combat stress behaviors -- consequences

Positive Combat Stress Behaviors	Misconduct Stress Behaviors	Battle Fatigue
Unit Cohesion	Mutilating Enemy Dead	Hyper-alertness
Loyalty to Buddies	Not Taking Prisoners	Fear, Anxiety
Loyalty to Leaders	Killing Enemy Prisoners	Irritability, Anger, Rage
Identification with Unit	Killing Noncombatants	Grief, Self-Doubt, Guilt
Traditions	Torture, Brutality	Physical Stress Complaints
Sense of being Elite	Killing Animals	Inattention, Carelessness
Sense of Mission	Fighting with Allies	Loss of Confidence
Alertness, Vigilance	Alcohol and Drug Abuse	Loss of Hope and Faith
Exceptional Strength and	Recklessness	Depression, Insomnia
Endurance	Diminished Discipline	Impaired Duty Performance
Increased Tolerance to	Looting, Pillage, Rape	Erratic Actions, Outbursts
Hardships, Discomfort,	Fraternization	Freezing, Immobility
Pain, and Injury	Excessively on Sick Call	Terror, Panic Running
Sense of Purpose	Negligent Disease, Injury	Total Exhaustion, Apathy
Increased Faith	Shirking, Malingering	Loss of Skills and
Heroic Acts, Courage,	Combat Refusal	Memories
Self Sacrifice	Self Inflicted Wounds	Impaired Speech or Muteness
	Threatening/Killing Own Leaders	
	Going Absent Without Leave, Desertion	Impaired Vision, Touch, and Hearing
		Weakness and Paralysis
		Hallucinations, Delusions



commanders as these behavior patterns are necessarily of disciplinary nature and therefore should be addressed on the same footings.

- Treatment of Posttraumatic Stress Disorder:

  Posttraumatic Stress Disorder requires specialized and expert handling and management by the psychiatrists. This area also needs rehabilitation services of Welfare Institutions.

iv) Combat Stress in Pakistani Millieau:

Wars change people and as it has influenced the lives of so many, it is presumed that the Pakistani soldier has also sustained the afflictions of wars. The very fact that no data is available on the subject despite multiple quotations of incidences in the war chronicles written by senior veterans of war indicate that the victims are still out there waiting for somebody to listen to their grieved hearts and wounded souls.

Although Positive Combat Stress Behaviors are recognized and given its due importance by many commanders but few remarkable aspects are ignored such as inculcation of a sense of purpose. At the same time there appears a complete ignorance for the concept of Dysfunctional Combat Stress Behavior and Posttraumatic Stress Disorder and their management. It is needless to say that these are assumptions based on the

author's own observations and need to be studied and researched further.

Soldiers of Pakistan Army come from varying backgrounds and cultures. Their educational status and motivations are also as varied as the variety of languages and dialects that they speak. All have different psychosocial perspectives and issues. There are also those who come from a family tradition of Army. All these jawans undergo a set of training focused on military bearing and acquisition of skills of warfare. Few get a chance to experience live combat. Most of these soldiers use their knowledge and skills learnt in the training days to fight for the motherland. None of them realize that their lives would be changed forever once they come back from war. Not knowing what has changed, they turn to their seniors for answers. Not able to find any resolution they carry out the rest of their lives trying to find remedy for their psychosocial handicap. Others may find relief in Misconduct Stress Behaviors.

To address these issues the author proposes a plan to carry out a psychological investigation into the structure of our soldiers mind, its way of functioning during war, his methods of tackling various stresses during combat, causes for his psychological vulnerabilities and finally to make efforts to decrease or remove them.

v) Proposed Plan for the Project:

a. Phase-I

   Collection of data from combat experienced troops and non combat experienced troops to find evidence for combat stress and determining various statistics.

b. Phase-II

   Interpretation of this data to formulate a manual / training instructions for junior leaders and officers, for training institutes like PMA, JLA, Command and Staff College and other schools of instructions to help achieve Primary Prevention.

c. Phase-III

   Running training workshops and cadres for training of mental health professionals and other physicians, to help them handle Combat Stress Casualties more effectively. This will let us achieve Secondary and Tertiary Prevention of Combat Stress.

d. Phase V

   Development of Combat Stress Control Teams, to reach the casualty in the proximity of their situation, to treat them and ensure their early return to duty.

CONCLUSIONS

Combat stress is a subject of Trauma Psychiatry which is a specialized field requiring research and evaluation of the prevalent combat related situation of the troops, training of manpower and development of a faculty of specialized mental health professionals and supervision of the different projects. This Psychological Trauma Centre does not only provide necessary direction for the Combat related stress and psychiatric consequences but also provides a platform for development of services for other kinds of disasters.

Taking into account the current world scenario where disasters of all kinds have become a common happening, there is a dire need to establish a centre for training and evaluation of these war casualties and develop a strategy for their prevention and treatment. There is strong evidence that by reducing combat related psychiatric sequelae, the outcomes of the wars can be changed. This proposed centre can help the Armed Forces take a direction towards achieving

those results. The above mentioned plan can be implemented effectively under the proposed Psychological Trauma Centre.

REFERENCES

1. Belenky G, Franklin DJ; **Combat - An Evolving Field 1987.**
2. Belenky G, **Contributions in Military Studies 1987.**
3. Virtual Naval Hospital Training Manual for **Combat Stress Control 2002.**
4. Donnelly C; Korean War - lessons in reference to **Combat Stress 1985.**
5. Yehuda R, Posttraumatic Stress Disorder in the Vietnam Veterans - Myths and Realities; **Am J Psychiatry 1995.**
6. Belenky G, Manning FJ, Ingraham LH; Contemporary studies in **Combat Psychiatry 1986.**
7. Crocq L, Crocq MA; Trauma and personality in causation of **War Neurosis 1987.**
8. Kellet A; **Combat Motivation 1987.**
9. Gregory Belenky, MD, Col., MC; Future of **Combat Psychiatry 1997.**
10. Field Manual 22-51; Leaders Manual for Combat Stress Control; 2004; Source: HSHA-PO, FSH, TX 78234-6142 DSN 471; **Com (210) 221-6985/8342.**
11. Combat Stress Actions Office, Dept. Preventive Health Services, **AMEDDC & S, MCCS - HPQ, FSH, TX 78234-6142, (210) 221-6985 (DSN 471); 2003.**