THE PSYCHIATRIC CASUALTY OF WAR†

A. LEVIN, M.B., Ch.B.*

'n Oorsig van psigiatriese ongevolle ten tye van oorlog word gegee. Dis reeds in 1904 beskryf. Oorsake en die kliniese beeld (in twee fases) word omskryf. Daar word na die situasie in Israel, waar vyf oorloë in 25 jaar onderwind is, verwys. Onder behandeling word keuring van soldate, voorkoming, akute en chroniese toestande, asook terugkeer na die slagveld bespreek. Die skrywer raak ook die kwessie van burgerlike ongevalle en die invloed op die familie van soldate aan.

Battle fatigue or war neurosis was first described in the Russo-Japanese War of 1904, when combatants were found to suffer from psychiatric states that could not be attributed to any known mental disease.

Observers could not grasp the concept of a situationally induced mental disorder. Instead they attributed the high incidence of psychiatric disorders amongst combatants to exposure to shells and high explosives, the concept of "shell shock" which was further reinforced during World War I when war neurosis was so common in the trenches and appeared to be related to enemy shelling.

We have subsequently learnt:

1. that shells themselves are not the cause of battle fatigue and that situational stress can produce anxiety reaction;
2. that this can occur in so-called normal personnel as well as in those who are particularly vulnerable, e.g., the neurotic;
3. that prompt intervention with the aim of assisting adjustment of the combatant to his situation is far better than total withdrawal to the rear. (Once the combatant with battle fatigue was withdrawn, he rarely came back to the front without even more heightened anxiety);
4. that the therapeutic community with the mental health team is a valuable form speeding up treatment.

Causation

Battle fatigue or war neurosis is the result of both high intensity terror and long-term unbroken stress. For the average combatant in World War II the preceding period of unbroken exposure to stress of enemy attack was found to average 42 days. It did not matter whether the sufferer was in a trench which was being shelled, or under enemy attack while being pinned down in a foxhole, or in a bush dugout, or simply being pinned down and cut off from the rear.

Where the relationship of the combat group was poor and military training and discipline inadequate, battle fatigue arose earlier.

Battle fatigue is prevented by the following:

1. Good group identification with its "buddy" system with a strong leadership hierarchy and good discipline. These are vital in maintaining the psychiatric health of the combatant. Chaos leads to battle fatigue. Order mitigates against it. Highly motivated troops with good morale allow for superhuman effort.
2. Physical well-being, adequate sleep, freedom from fear (including the fear of dying or being maimed which excessive casualties tend to reinforce).
3. Hope of success and victory. These are the key factors.

Symptomatology

Battle fatigue presents in its **initial phase** with heightened anxiety, restlessness, agitation, initial and middle insomnia, tachycardia, butterflies in the stomach, reduction of appetite, moist palms, irritability, etc. This phase may last for hours, days or months. The more vulnerable person may experience a hysterical conversion reaction with inability to walk, talk, or move, or may dissociate colloquially (bosbedonderd or bush bush). If in addition the person is drinking excessively, the problem becomes even greater.

Phase two: Chronic fatigue or withdrawal phase. During this period the patient starts developing features of fatigue and of endogenous depression. The person becomes withdrawn, quiet and asocial, is losing weight, eats poorly, has impaired concentration, impaired memory, and sluggish reflexes, is anxious yet demonstrates little anxiety physically, is vaguely depressed and may become morbidly so with feelings of impending doom and death, has reduced self control and inhibition level and generally invites death by enemy fire. This is the "zombie" type figure of the Bridge at Remagen.

Battle fatigue need not only occur under conditions of death or disaster. This syndrome may occur in the most vulnerable group without even coming into contact with the enemy; one can have battle fatigue without ever having seen a shot fired in anger. Purely anticipating combat is enough to cause symptoms in a very frightened person.

The victim of war disaster

Sudden overwhelming unexpected disaster endangering life or the lives of loved ones causes people to act rather differently from the normal controlled manner of ordinary circumstances.

One of the problems with sudden disaster is that there is no warning; lack of warning compounds the disorganisation and confusion that follow. When people do not expect war or disaster, they tend to freeze or panic more easily. Whether they freeze, whether they are immobilized or whether they panic and act out depends to some extent on personality. Those who under stressful circumstances become withdrawn or depressed would under the impact of disaster become more prone to be immobilized and freeze, while those that tend to act out and yell and shout at the best of times will only yell, shriek and shout louder under the impact of stress. The more overwhelming the disaster, the more vulnerable the person is to inappropriate response. This is why gradual disaster with one crisis sparking off another tends to be beneficial to the person's ability to cope with crisis; anticipation of crisis is healthy. It is the sudden loss, the sudden bereavement, the sudden fear of death for which the person is not prepared that is dangerous.

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*Principal Psychiatrist, Addington Hospital, Durban.

The reason for Israel's tremendous ability to cope with 5 wars in 25 years was the experience of the previous war that helped the person cope better with the next one. On the other hand, the fact that there were far more psychiatric casualties during the October (Yom Kippur) War was the result of lack of anticipation and preparation for the war which caught Israel to a large extent off guard. To be lulled into a state of false security is more dangerous than some rattling and preparing for war and disaster.

Crisis/disaster plans have the additional advantage of attuning a person to a very different type of behaviour — they offer a form of desensitization to the horror, a method of teaching the person to act automatically and efficiently in a crisis. Without this conditioning, the individual is far more vulenrable. Preparing for disaster prevents disaster.

TREATMENT

Selection

It is advisable to weed out before referral for military training persons who have a low threshold to anxiety or who are afraid. In this manner one is following the advice of the Bible to Gideon's band to thin out their ranks of the lovers, the homesick, the poorly motivated, etc.

Prevention

Frequent rotation of front-line troops for short periods of rest and recreation in the communication zone or area just behind the front line is advisable. In very acute circumstances this should be done every few days. Morale, leadership, housing and feeding are important preventives.

Treatment of the early case

Withdrawal from the front line to the communication zone with rest and recreation and sleep for 12 hours is indicated; when the anxiety has lifted, return the patient directly to the combat unit.

Treatment of established battle fatigue

Withdrawal to a specialised psychiatric unit, preferably close to the front line is advised. **Sargant and Slater** recommended abreaction, reliving of the experience that helped to precipitate the state of battle fatigue catharsis. This state of abreaction is best obtained through the injection of either a benzodiazepine such as diazepam, Rohypnol or other similar sedative or hypnotic or even old-fashioned sodium thiopentone in very small titrated doses.

Another method is the Kaufmann method of hypnosis in the field.

Following on the catharsis, a portion of which takes place on a subconscious level and is not fully remembered in the conscious state, the material elicited in the semi-conscious abreacting state is discussed repeatedly in the waking state. In addition, some authorities believe in periods of sleep therapy and others insist on regarding the state as at least in part a depressive reaction of psychotic proportions and may give Anafranil infusions or other antidepressants in heavy dosage.

At times the abreaction may be so severe that it has to be broken and for this purpose major tranquillizers such as Trilafon injection or Serenace injection are used in doses of 5-15 mg.

Return to combat

If the person responds well and is highly motivated, he should be allowed to return to combat. If an underlying psychotic process or a severe anxiety remains, the person should be removed to a rear hospital for more intensive treatment. The more acute and more intensive the treatment, the better the prognosis.

The civilian, non-combatant casualty

Few things are more disrupting or more terrifying than a life endangering situation in which one finds oneself caught in cross-fire. The civilian victim who has no control over his environment and cannot defend himself, is caught in the most immobilising of psychiatric states, referred to as an avoidance conflict. He cannot run because there is nowhere to run to, and he cannot fight because he has not the weapons to fight with. This results in a very similar state to battle fatigue with civilians having the highest casualty rates and the poorest medical and psychiatric services. For civilians, the best and only treatment is to withdraw them from the battle zone and to allow group interaction to give support and consolation.

The combatant's family

The disorganisation of war results in the breadwinners, fathers, mothers, brothers, husbands and wives being removed from their usual role, with loss of family cohesiveness. While peer group influences might protect the child, both husband and wife are the prey of their emotions; infidelity, making hay while the sun shines, causes a gross disorganisation in previously adjusted families. A family is never the same after a war, and generally not altered for the better.

In closing, we must say that just as war produces physical cripples, invalids, amputees, and deaths, so also does war produce psychiatric casualties. Amongst combatants the greatest risk is that the person with battle fatigue will become vulnerable as a soldier wih a grossly heightened mortality rate; he becomes a mortality statistic.

For those that are treated and recover, scars tend to remain in the form of heightened anxiety levels.

A large proportion of casualties are left with both physical and psychological problems, e.g., the amputees and paraplegics. The psychiatric approach is to allow for strong emotionally laden grief. The person must be allowed to face and accept reality and come to terms with it. In addition, the support of a group of fellow sufferers who share the same disability is more valuable than individual psychotherapy.

The key person is the matter-of-fact, encouraging yet realistic physiotherapist who acts as a group leader for what is a group therapy session in action for 18 hours a day.

The family should also be consulted about how to handle the amputee and they can do no better than watch and participate in the activities of the amputee rehabilitation physiotherapy unit in action and apply the same methods.

On the other hand, let it be unequivocally stated that war does not produce psychopaths or make people violent; the opposite has been proved, that men who have experienced war tend to become less violent.

On the other hand, war provides the opportunity for the psychopath and for the anti-social to commit anti-social acts without the same sanction that apply in peace time.

The worst casualties of war are civilians and families. A disorganisation occurs in their lives from which they may never recover; without on-going and intensive support by the society in which they live and by its medical services, their lives may bear the scars for the rest of their days. The one message that comes through is that countries must be strong enough to remain at peace.